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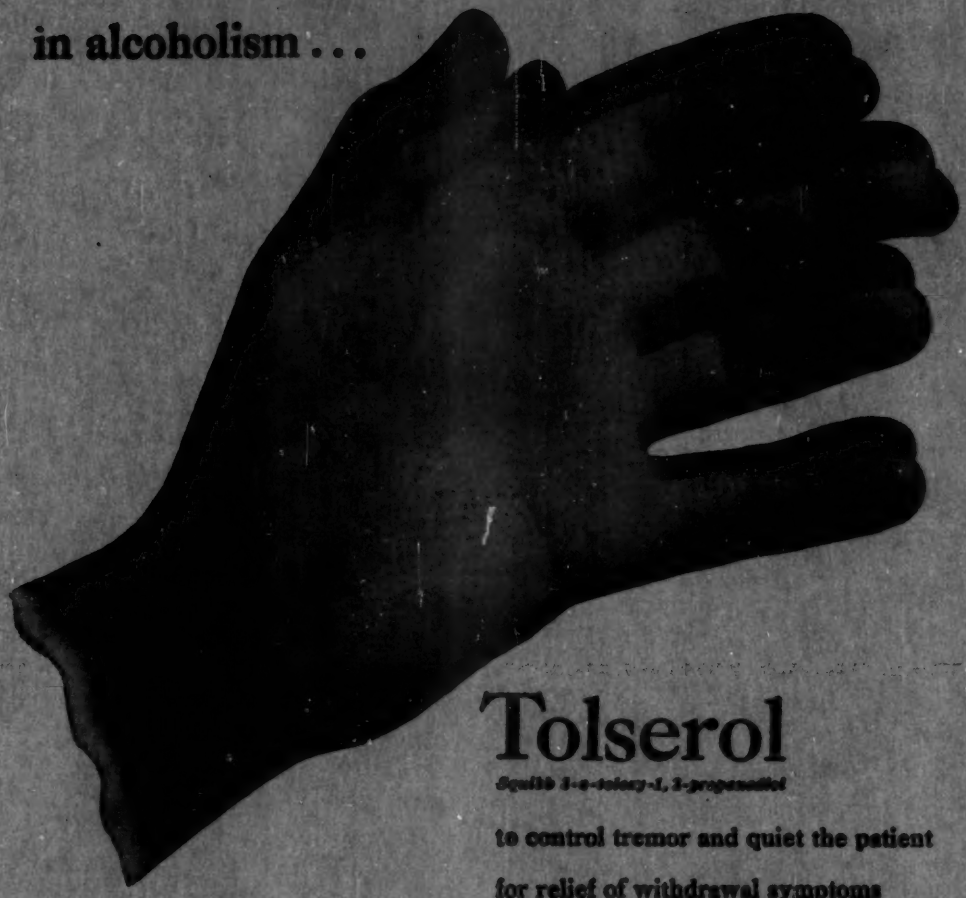

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OCTOBER

CONTENTS

1952

THE AMERICAN PSYCHIATRIC ASSOCIATION

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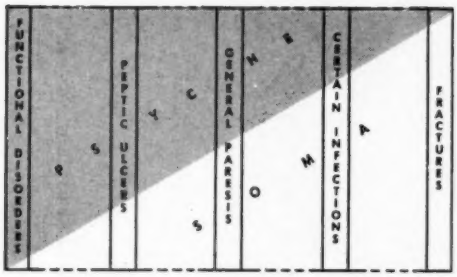
Therapy for Mixed Somatic and Psychic Complaints

Illness may be divided into:

a.) that which begins by a disturbance of function with physical breakdown (primary organic).

b.) that which begins in the psychic or emotional sphere and may eventually lead to physical breakdown (psychosomatic).

Stevenson[1] categorizes diseases according to the relative amounts of *psychic* and *physical* manifestations uncovered during interview with the patient. Burlingame's[4] classification, upon which the following chart is based, evolved from a similar thesis.



Diagnosis: people differ widely in their predisposition toward disturbances of emotional origin. The patient with greater constitutional predisposition develops illness under a relatively low level of stress; whereas the more stable individual can make good adaptation until exposed to a higher intensity of stress. For this reason examination should evaluate:

A.) Factors such as —
Emotional stability and family history.
Interpersonal relationships.
Life situations at work, in family and social areas. (Stevenson[1])

B.) *Complaints offered by patient* —

e.g. { lump in throat, substernal pain, palpitation, sweating, fatigue, sick to stomach, diarrhea, menstrual irregularities.

C.) *Complaints elicited by questioning patients*–

e.g. { admission of chronic anxiety, irritability, fear of illness and/or economic loss etc., difficulty in dealing with others.

D.) *Findings on examination of the patient:* muscular tenseness, moist skin, dry mouth, variable pulse rate etc. (Ebaugh[2])

Ebaugh[2] reports that somatic manifestations of such illness are intimately related to the balance between sympathetic and parasympathetic nerve tonus. Since emotions relayed via the hypothalamus, activate both adrenergic and cholinergic discharges, continuous emotional stress and anxiety result in functional disturbances.

Treatment of such conditions, therefore must be based on two methods of management:

1.) *psychotherapeutic* — to help patient adjust to stressful situations with minimal emotional trauma.

2.) *medicinal* — to relieve the patient's symptomatic distress and concern over his illness, thereby making him more amenable to psychotherapy.

Bellergal — is particularly suited as an adjunct to psychotherapy for functional disorders. MacFadyen[3] explains the rationale of this therapy as follows. Bellergal contains:

1.) *Ergotamine tartrate and Bellafoline*—these block sympathetic and parasympathetic impulses respectively, thus inhibiting transmission of stimuli which originate from emotional centers.

2.) *phenobarbital* — which inhibits the exaggerated response of the neurotic patient to stressful situations.

This combination ". . . subdues the central, sympathetic and parasympathetic activities in such a manner that the dominance of any one division is gradually decreased to a point where normal balance is re-established."[3]

BIBLIOGRAPHY

1. Stevenson, I.: G. P. *4:* 59, 1951.
2. Ebaugh, F.: Postgrad. Med. *4:* 208, 1948.
3. MacFadyen, B.: Am. Pract. *2:* 1028, 1951.
4. Burlingame, C.: Connecticut M. J. *14:* 493, 1950.

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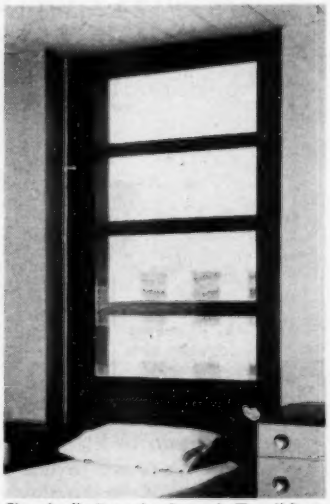

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SURVIVAL FACTORS IN AMERICAN PRISONERS OF WAR OF THE JAPANESE[1]

J. E. NARDINI, CDR. M.C., U.S.N., NEW YORK, N. Y.

I. INTRODUCTION

The following comments are based on a 3½-year period of firsthand observations on American prisoners of war of the Japanese taken in the Philippine Islands in 1942. The writer served as a Medical Officer in prison camps in the Philippine Islands and Japan with members of the 30,000 American military prisoners captured by the Japanese Imperial Army with the fall of Bataan and Corregidor in April and May of 1942. The period of imprisonment lasted for 3½ years, until September 1945.

It is hoped that, with the passage of several years' time, and some increase in psychiatric knowledge and experience in the writer, a more balanced perspective has been achieved and made possible a more accurate and meaningful report.

Approximately 12,000 or 40% of the 30,000 men of the Army, Navy, and Marine Corps survived the period of imprisonment. It is the purpose of the present article to outline the factors that made survival difficult and to point out the individual qualities that most favored individual survival.

During the 5 months of active combat (December 8, 1941, to May 6, 1942), the men were exposed to inadequate food intake, active combat conditions, tropical weather, anxiety induced by awareness of an inferior military position, frequent poor leadership, and physical disease in the form of malaria, dysentery, and vitamin deficiencies.

The ignominy of capture with its attending emotional impact came on April 9, 1942, for the forces on Bataan, P. I., and on May 6, 1942, for the forces on Corregidor, P. I.

Our national group experience accustoms us to protection of individual rights and recourse to justice. The members of this group found themselves suddenly deprived of name, rank, identity, justice, and any claim to being treated as human beings. Although physical disease and the shortages of food, water, and medicine were at their highest during this period, emotional shock and reactive depression played a great part in individual inability to cope with physical symptoms and disease, and undoubtedly contributed much to the massive death rate (approximately 4,000 of the 30,000 American prisoners) during the first months of imprisonment from April to September 1942.

II. CONDITIONS OF IMPRISONMENT

Conditions of imprisonment varied from time to time in different places and with different groups. In general there was shortage, wearisome sameness, and deficiency of food; much physical misery and disease; squalid living conditions; fear and despair; horrible monotony almost completely unrelieved by pleasurable interludes; inadequate clothing and cleansing facilities; temperature extremes; and physical abuse.

Food consisted primarily of rice and soup with occasional very small amounts of meat, dry fish, or vegetable. The insufficient quantity resulted in constant hunger and loss of weight. The insufficient quality took its toll in vitamin deficiency diseases, weakness, and many deaths. Hungry men were constantly reminded of their own nearness to death by observing the steady relentless march to death of their comrades. The death rate in the main prisoner camp at Cabanatuan, P. I., was between 40 to 60 per day in a population of 6,000-9,000, or roughly 1% per day during the months of June, July, and August of 1942. Hungry men were often reduced to attitudes and actions incompatible with their own previously accepted levels of behavior and self-respect. Men quibbled over portions of food, were suspicious of those who were in more favored positions than themselves, participated in unethical barter, took advantage of less clever or enterprising fellow

[1] Read at the 108th annual meeting of The American Psychiatric Association, Atlantic City, N. J., May 12-16, 1952.

The opinions expressed in this paper are those of the author and do not reflect official opinion of the Navy Department.

prisoners, stole, rummaged in garbage, and even curried the favor of their detested captors. There was a great distortion of previous personality as manifested by increased irritability, unfriendliness, and sullen withdrawal(1). Hungry, threatened men often found it difficult to expand the horizon of their thinking and feeling beyond the next bowl of rice. Added to this hunger was the haunting fear that the supply of food might at any time with little cause be reduced or even stopped.

Disease was abundant(2). Fever, chills, malaise, pain, anorexia, abdominal cramps from recurrent malaria (acquired in combat), and dysentery plagued nearly all and killed thousands. Treatment was rarely adequate. Physical work was often required of men suffering with physical illness, which usually aggravated physical symptoms and hastened demoralization and death. Beriberi contributed symptoms of painful feet, anorexia, cardiac failure, loss of vision and led at times to death. With xerophthalmia came sore eyes, corneal ulcers, and subsequent impaired vision. In addition there were assorted outbreaks of diphtheria, flu, typhoid fever, along with tuberculosis, pneumonia, and various surgical conditions and their complications. Separate or associated with the above diseases, most men experienced bouts of apathy or depression. These ranged from slight to prolonged deep depressions where there was a loss of interest in living and lack of willingness or ability to marshal the powers of will necessary to combat disease. An ever-present sign of fatal withdrawal occurred 3 to 4 days before death when the man pulled his covers up over his head and lay passive, quiet, and refusing food. In some such cases active measures were life saving—these included support to the ego with praise, talk about the man's folks at home with inference of his responsibility, indulging his extreme dependence, and these failing, systematic prodding to anger. It was fascinating to watch this last mechanism operate within the group as a group survival mechanism.

Facilities for care of the sick were crude and primitive. Medical care was highly inadequate; prisoner doctors were given little latitude in treatment and were usually not supplied with adequate medicine to deal with the diseases present.

Living conditions were uniformly miserable. Men were exposed to extremes of temperatures, heat in the tropics and cold in the northern climates. Clothing, bedding, and housing were insufficient and contributed much misery. Camps were dank, dismal, and dreary. Lack of soap and warm water fostered troublesome skin lesions. Body lice and fleas were well fed and multiplied in abundance. Delousing facilities were almost nil. Tired, weak, sick men performed hard physical work on farms, in factories, ship yards, docks, coal and copper mines.

There were many complex psychological and mental handicaps to torment the men further. One of the most distressing features was the highly indefinite period of incarceration. The future offered only visions of continued hunger, cold, disease, forced labor, and continued subservience in the face of shouting, slappings, and beatings. All men were envious of prisoners at home who were serving known terms. The ennui and monotony of imprisonment were similar to, but deeper than that experienced episodically by combat troops. Strong hostility naturally arose from the extreme frustration of involuntary enforced incarceration. Little could be done with these hostile feelings. It was necessary to retain kindly feeling to the mother country for there alone lay ultimate salvation. It was not possible to demonstrate recognizable signs of hostility to the captors for obvious reasons. Therefore, where there were mixed groups of Allied prisoners, much hostility was turned from group to group and in other instances to individuals within the group. There was no escape from continued daily contacts with irritating incompatible fellow prisoners. In many cases hostile feelings were obviously turned inward and joined with appropriate feelings of frustration to produce serious waves of depression. All men experienced a smothering hemmed-in feeling with strong yearning for freedom of movement and freedom from oppression. The sight of sickness and death of friends increased the burden of many. Self-pity, which some indulged, was highly dangerous to life. Lack of specific knowledge of the course and state of the war and the infrequency of news from home further aggravated the sense of isolation and abandonment.

Under the existing conditions, the absence

of sex did not seem to create serious or widespread problems. In this situation, it can be safely said, the sex drive varied in direct proportion to the food supply, and in inverse proportion to hunger. When the men were experiencing anxiety, depression, disease, or hunger, sexual drive was minimal and in many cases nonexistent(3). During periods of improved food intake and improved health, as observed at the Cabanatuan Prison Camp from February of 1943 to October 1943, sexual rejuvenescence was apparent. Sexual interest was reflected by an increased incidence of nocturnal emissions, by masturbation, and by homosexual practices—overt in a small susceptible group, covert in a much larger number of the men. Camp plays placed emphasis on female impersonations and female roles. Homosexual practices became a subject of group knowledge and discussion and almost reached a level where internal official measures needed to be applied. The problem disappeared spontaneously and rapidly with the depreciation of the food supply. Some men went through the imprisonment experience with a greatly reduced or absent sexual drive—some, for example, experienced no erections for as long as a year at a time. Some continued masturbation irregularly through the entire period. The deprivation of sex was not a major or serious problem to most men under the circumstances.

There were many direct physical and moral abuses from the Japanese. At least 90% of the men received some direct physical punishment at some time during their imprisonment. Punishment was meted out mostly by low-ranking soldiers or ex-soldier prison guards and less often but frequently by higher ranking enlisted soldiers and officers. The reasons for punishment varied from none whatever to violations of orders. When it is realized that race hatred in the Oriental had been built up to an intense level over the preceding generations it is not difficult to see how much nonspecific violence was directed to the white prisoners. Prisoners represented the actual physical presence of the much hated white race. This, combined with a considerable capacity for sadistic behavior in the Japanese personality, accounted for the infliction of much physical abuse on the prisoners. All prisoners were required to salute all Japanese military when covered and to bow stiffly from the waist if uncovered. Failure to do so or even imperfect technique brought punishment. The favorite and universal Japanese approach to asserting dominance consisted of a loud raucous exclamatory "Kioski" (Attention!) followed by fierce animalistic fury of incomprehensible shouting in Japanese topped off with slapping or hitting. The recipient was required to remain standing at attention, silent and motionless. Any deviation from this called for greater beatings or imprisonment. When the ire of the punisher subsided sufficiently or the victim was no longer able to stand, the session was terminated. Slapping at times was administered with sticks, straps, wooden clogs, or any convenient wieldable object. Every unit, no matter how small, harbored one strongly sadistic creature whose main daily satisfaction was derived from inflicting beatings. Even the most cautious and circumspect prisoners for one reason or another came in for some degree of punishment. There were many obvious efforts to break the morale and spirit of the prisoner group. Clothing, food, mail, and Red Cross packages were often intentionally seized, destroyed, or kept from the men over long periods when they were bitterly needed. Men marched through the city streets of Japan long distances to work, tattered, torn, and weak. Physical exercise in the form of calisthenics was demanded of all men before, during, and at the end of the day's hard work. Threatening speeches were made to individuals and groups with humiliating implications. For minor reasons, men were placed in camp jails and solitary confinement with reduced food and cover. Many developed serious illness, including pneumonia, dysentery, and gangrene of the extremities from this treatment. Several executions were held openly on prisoners who had tried to escape from the Cabanatuan Prison Camp. Men were transported in unmarked ships and housed in unmarked camps ashore. At various stages of the war, prisoners ashore and in transit were subjected to bombings by our own planes, torpedoeing by our own submarines, and shelling from shore installations. Several thousand men were lost in this manner. Some camps were

worse than others. It was not unusual for men to break their bones in order to get out of such a "worse" camp and be taken to another area; one such area was Palawan, P. I., where nearly 200 men were finally herded into a shack, burned or shot to death. Only a few survived to tell the tale.

To summarize, the major factors that had to be dealt with in order to survive were these: the initial shock and subsequent reactive depression induced by being taken prisoner by Oriental people; the feeling of being deserted and abandoned by one's own people; the severe deprivation of food, warmth, clothes, living comforts, and sense of respectability; the constant intimidation and physical beatings from the captors; loss of self-respect and the respect for others; the day-to-day uncertainty of livelihood and the vague indeterminable unknown future date of deliverance.

III. SURVIVAL FACTORS

The "instinct" of self-preservation in man and animals is often used to describe an unwitting or subconscious drive to retain a hold on life even in the face of threat. "Instinct" applied to man does not provide the entire answer. Granted that we derive some blind basic drive for continued life from our animal ancestry, we also by virtue of reason, foresight, and capacity to perform rational acts are capable of bringing life under conscious will or control. This imprisonment experience provided a unique opportunity to observe what happens to the human will to live under prolonged severe stress. What is the will to live? Is it stronger in one than in another? If so, why? Can it be modified or influenced? Does everyone have a breaking point where he is willing to give up? Was the stress of this experience materially different from that of everyday life?

Much has been written of the will. Without making detailed reference to philosophic, religious, or psychiatric concepts of free will, it is here advanced that what freedom of the conscious will man can muster and operate was shown to be a tremendous positive factor in survival. Where the will to live was for any reason weak, death seemed to come readily even with lesser physical ailments. On the other hand, where the will was firm even in the presence of serious physical illness, life often continued. Since the will to live was of primary importance it might be worth stating some factors that seemed to sustain that will in the presence of prolonged stress of this particular type. In brief, willingness to continue living depended on the effectiveness of psychologic defenses in preserving the strength of the ego and feelings of self-esteem. It was essential to conceive of one's self as something better than the environment implied. It was important to look forward and backward and retain an active identification with one's home countrymen instead of with the miserable prisoner group. Where this will to live was weak in the beginning or defenses were poor or both, chances for survival were diminished. The individuals who too closely merged with their prison environment and who as prisoners felt like prisoners fared badly. A successful defense in this area was a persistent recollection that one was an American, a westerner, a Texan, a soldier, an officer, a father, an artilleryman, or some other acceptable ego-supporting concept. The will to live in everyday ordinary circumstances seems to be sustained by the existence of a favorable balance of everyday satisfaction with the past, present, and some reasonable hope for the future. These men had to overlook, repress, or ignore the present, and place undue emphasis on past and future(4).

The conscious and subconscious motivational factors for continuing life were by far the most important features favoring survival. Individual differences ranged from giving up in the very beginning at the mere prospect of imprisonment to tenacious holding on through all the vicissitudes in the years of travail mentioned earlier. Those who gave up earliest and easiest were the younger men, viz., in the 18-22 years span, who lacked the maturity, philosophic concepts, fortitude, independence, and the buffering effect of at least several years of military experience, which they needed to withstand the initial shock. It is noteworthy that this age group corresponds to the age group with the highest incidence of combat fatigue in combat conditions(5). The nature of the conscious motivation was unimportant. Some had an extreme desire to see and be with

loved ones. Some lived for the opportunity of again tasting the pleasures of life once taken so much for granted—a cool beer, hot dogs, a steak dinner, home cooking, a new car, a clean bed with a mattress, the home town, the mountains, or just plain freedom. Some were motivated primarily by a stubborn refusal to be dominated and overcome by inferior people.

The more men experienced depression and regression with physical illness, the more readily did they part with the strong desire to live and enjoy the future. Those who went into illness with some realistic appraisal of the gravity of the situation and had a firm intention to hold out as long as possible were more likely to survive the illness. On the other side, those who developed depression for psychologic reasons were very likely to rapidly develop physical illness. At times it appeared simply that some were naturally weak willed and others brave. In a very general way it can be said that a previous stable personality was an asset. Defensive mechanisms used to combat previous troubles of lesser degree were drawn upon again. Those included the following: escape as controlled autism, study, and drama; refusal to face reality, as overoptimism (a hazardous defense in this situation), overpessimism (generally more effective); "be friendly and on good terms with the enemy then he won't hurt you;" repression and suppression of knowledge of the ever-present danger of death with a kind of obsessive conviction that one would make it somehow; and pleasurable fantasies of the enemy taking a beating elsewhere in battle.

Cleverness, adroitness of thinking and dealing with people, and general cunning were often great contributing factors to survival whereas pure intelligence unrelated to interpersonal dealing and long-range prediction was of less advantage. The more sense of humor an individual was able to retain the greater were his chances of survival. It is difficult to state whether the capacity to see humor even in sordid situations contributed to livelihood and survival or whether it was simply that those people who had retained a sense of humor were strong in other ways that aided survival. A well-controlled and strong fantasy life was helpful for many when correctly applied in an optimistic direction. Good discriminatory judgment and emotional balance were obvious advantages. A willingness and desire to keep busy but not to work too hard in order to conserve energy were highly desirable. Courage was essential but too much could be troublesome unless applied with a long-range view. Direct fighting-back or escape were in most instances completely out of the realm of possibility and only brought further travail and in some cases tragedy. Many were helped to tolerate the misery of confinement by finding an effective but disguised way of striking back at their captors. These measures included surreptitious acquiring of news; bribing of Japanese guards; utilizing knowledge of the natural Japanese schizoid-paranoid temperament by playing one against the other; smuggling news, letters, food, Japanese dictionaries, and medicines; and in some instances successful contamination of the captor's food.

Occasionally an individual would develop a depressive reaction in which he would lose interest in himself and his future, which was reflected in quiet or sullen withdrawal from the group, filth of body and clothes, trading of food for cigarettes, slowing of work rate to a level that invariably invited physical abuse from the Japanese and an expressed attitude of not giving a damn or what's the use. If this attitude was not met with firm resistance by companions, camp leaders, or medical personnel, death inevitably resulted. The most successful measures in combating this reaction included forced hot soap-and-water bathing, shaving and delousing, special appetizing food, obtaining a few days rest in camp, and if possible temporarily easier work conditions, a mixture of kindly sympathetic interest and anger-inducing attitudes. Victory was assured with the first sign of a smile or evidence of pique.

There were spontaneous undirected protective group mechanisms that favored survival. As with all groups oppressed by a common, easily recognized oppressing force, here too an automatic group cohesive force eventually developed. This force was in conflict at times with measures that favored individual survival, and was handled differently by different individuals. The clearest ex-

ample is in attitudes toward escape. All men were grouped into shooting squads of ten. If one or more of the group escaped, the remainder were to be shot. Thus escape or attempted escape simultaneously meant jeopardizing the life of one's fellow prisoners. Attempts at escape in the P. I. and Japan were infrequent and rarely successful. I have immediate personal knowledge of only 3 separate escape attempts involving 5, 1, and 2 men. All were apprehended and executed. In 2 of these instances the remaining members of the group were punished but not shot. I believe in most instances the major deterring influence to escape was realization of the overwhelming odds against success with sure death if recaptured. Some were deterred to some extent by knowledge of punishment to the remaining members of their group. Another example of subconscious group protective reaction was the relative infrequency of fighting between individuals within the prisoner groups, even in the face of strong provocation. The infrequency seemed greater than could be explained by the lowered physical state. Another group mechanism operated in the selection of leaders where this was permitted or possible. The small margin of error allowed the groups and the drastic effect of mismanagement influenced departure from older group or sectional bias in favor of selecting and supporting more able, honest, and courageous leaders.

Something must be said of differences in individual constitution. In general it seemed that thick, dark, stocky individuals seemed to wear better than thin, small-boned, tall, slender, delicate-framed individuals. Emotionally, the plodding, unresponsive, insensitive individuals did well, while more sensitive, previously sheltered, dependent individuals fared badly. Some of the sensitive individuals successfully balanced their sensitivity with humor or philosophic considerations. Pure luck, along with opportunism, in some instances, contributed to survival for many. Officers and professional personnel in general fared better than average due to the combination of higher natural endowment, and less rigorous physical work. Failures in adjustment were most apparent in the 18-to-23-year-old group who had little or no previous military experience and much previous overprotection. These men demonstrated marked inability to fight physical diseases and the initial shock of depression of captivity. A minimum of 8 or 10 years of military service seemed to provide some buffer against the physical and emotional hardships of imprisonment.

The next most vulnerable group was probably in the 45-to-55-year span and then 33-45, 55 plus, and 23-33 in order with the 23-33 year span having the most favorable status for survival. It might be noted that many of these men who survived made a gradual transition from the very different category of soldier to professional prisoner of war.

It is interesting to consider how certain psychiatric groups handled confinement. The huge majority of psychotic manifestations were seen as part of severe organic disease such as pellagra, cerebral forms of malaria, and acute toxic states. A small number with an incidence of roughly 1 per 1,000 per year could be classified as functional psychoses. This latter group fared badly and usually died of intercurrent disease. Some of the same individuals who demonstrated precaptive neurotic patterns of psychosomatic gastrointestinal and vascular symptoms, fugue states, hysterical manifestations, marked tension states in combat due to fear of being killed showed remarkably few disruptive or disabling symptoms under prisoner conditions. These individuals for a number of reasons were better able to accept and endure the quiet passive unassertive life with its long-range threat over the more hectic and often catastrophic aspects of active combat. The fact that relatively few demands were made upon them to exercise personal initiative and responsibility may have contributed much to their relative ease.

Suicide *per se* was rare. Many of those who died in response to the initial shock and during the course of disease were to some degree self-induced deaths of a passive nature. On the other hand active self-inflicted injury was rare. I know of only 3 active suicidal attempts. The first was an army officer who was found in his bed space in the morning exsanguinated from self-inflicted lacerated wounds of both wrists. One

wrist cutting by an enlisted man was unsuccessful, and the other attempt occurred in a schizophrenic patient. It may be that the ever-present long-range threat to life satisfied transient impulses to death, which made it unnecessary for an individual further to act out self-destructive feelings or impulses.

Psychopathic personalities were interesting in that they managed exceedingly well when assigned to extra camp jobs to which they seemed to gravitate, such as driving trucks or taking care of odd personal jobs for the Japanese, but fared very badly when kept under the same rigid restrictions as the rest of the men. In the latter circumstance they almost invariably became involved with the Japanese by virtue of foolish aggression or stubborn resistance, and also aroused hostility in their fellow prisoners. These men would then develop some degree of depression and apathy and waste away physically, and to death if unchecked. Several known alcoholics made excellent prisoner adjustments and expressed their oral needs through incessant vocalizations both awake and asleep.

Men with obvious low intelligence often fared badly, owing to poor planning and rationing of food and energy, poor self-care, lack of friends, and receipt of more than average abuse from the captors. A few known overt homosexuals were observed to be in unusually good spirits during periods when they were able to practice their arts. Their adjustments at other times were on a par with their comrades of equal age, intelligence, and rate.

Summary

The prolonged miserable circumstances of living during 3½ years of imprisonment as prisoners of war of the Japanese have been outlined. An estimated 12,000 of 30,000, or 40%, survived this experience unique in the history of American people. An attempt has been made to state some of the factors that seemed to the writer to influence survival favorably. These factors in summary consisted of a strong motivation for life with persistent exertion of will, good general intelligence, good constitution, emotional insensitivity or well-controlled and balanced sensitivity, a preserved sense of humor, a strong sense of obligation to others, controlled fantasy life, courage, successful active or passive resistance to the captors, luck, opportunism, and a few preceding years of military experience.

BIBLIOGRAPHY

1. Schiele, Burtrum, and Brozek, Joseph. Experimental neurosis resulting from starvation in man. Psychosom. Med., **10**: 31, Jan.-Feb. 1948.

2. Nardini, J. E. Vitamin deficiency diseases in allied prisoners of war of the Japanese. U. S. Naval Med. Bull., **47**: 272, March-April 1947.

3. Brill, N. Q. Neuro-psychiatric examination of military prisoners recovered from Japanese prison camps. Bull. U. S. Army Med. Dept., Vol. V, No. 4, April 1946.

4. Wolf, S., and Ripley, H. S. Reactions among allied prisoners of war subjected to three years of imprisonment and torture by the Japanese. Am. J. Psychiat., **104**: 180, Sept. 1947.

5. Raines, G. N., and Kolb, L. C. Combat fatigue and war neuroses. U. S. Naval Med. Bull., **41**: 923, Sept. 1943.

DISCUSSION

Col. Rawley E. Chambers (Fort Sam Houston, Tex.).—Commander Nardini has given, as an eye witness and participant, an objective, accurate, comprehensive, and factual report. I have referred his paper to several ex-prisoners-of-war for comment and they have confirmed the observations reported in every respect, and have unanimously agreed with the conclusions drawn. The author is to be congratulated on having written a highly interesting and informative paper that should add much to our understanding of these survivors in their attempt to maintain an adequate adjustment since their liberation. It is to be noted that the author himself has taken every advantage of the factors noted in the paper and has apparently encountered no insurmountable difficulty in maintaining his ability to adjust.

Since 1946 I have had the opportunity to observe, examine, treat, and make disposition of large numbers of ex-prisoners-of-war, and also to have been associated with a considerable number who still remain on active service. As a result of these experiences, it is apparent that the clinical picture presented, when considered in the light of previous personality structure, follows a rather definite and clear-cut pattern.

With relatively few exceptions the presenting complaints are usually as follows: fatiguability, lack of ability to withstand frustration, frequent resort to alcohol and sedative drugs, low resistance to physical illness, neuritic-type pains in feet and hands and frequently edema of the ankles and feet, irritability and other manifestations in varying degree of emotional instability, and a need for preferential duty assignments. Psychosomatic symptoms are frequently present.

On physical examination remarkably little is found in the way of structural pathology. Fairly common, however, are the findings of impaired sensation in feet and hands in the form of real neuritic impairment or, most frequently, as subjective paraesthesias. In many cases definitely abnormal electroencephalograms are found. Undoubtedly these are frequently the residual effects of the brutal beatings to which the prisoners had been subjected. Quite often intestinal disturbances such as chronic diarrhea are noted—possibly amebic in origin, but usually with psychiatric connotations. Most noticeable are the manifestations of chronic anxiety.

No definite conclusions can be made as to the degree of physical impairment as distinguished from strictly functional disturbances because of the relatively few exhaustive pathological studies available. It is logical to assume that, as the result of long-continued chronic debilitating diseases and severe vitamin deprivation, certain changes in structure and function of the central nervous system and other organ systems may result and form the basis for the remarkably uniform symptom complex.

Finally, the findings in these cases bear out the statements of Commander Nardini as to the facts reported and the conclusions drawn. Again, I wish to congratulate the author on an excellent paper.

RESTATEMENT OF COMBAT PSYCHIATRY[1]

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AND

BRIG. GEN. RAWLEY E. CHAMBERS, MC, USA[3]

Introduction

This paper concerns combat psychiatry and is a report to fellow psychiatrists of psychiatric doings in the Korean conflict. In the time at our disposal we shall not cover the subject thoroughly, nor restate the obvious and the well-known, but rather shall present a series of concepts and comments that are believed to be important and even basic to the successful understanding and handling of the problem.

Combat psychiatry may be said to start at the port of embarkation where, for the first time, the individual soldier's spatial situation is such that the possibility of his personally performing combat appears to be more than a remote intellectual abstraction.

Combat psychiatry is more than a doctor-patient therapeutic relationship. It is a larger relationship between many elements of the army based on the attitudes of military men of all echelons—a most difficult thing to define, and most flexible in application. The more recent history of combat psychiatry is to be found in references 1-3.

Occasionally, there is expression of dichotomous thinking that seems to hold that there are essential and wide differences between the aims of civil and military psychiatry, between the soldier and the civilian, and between military and civilian psychiatrists themselves. It is believed that the differences are only apparent and that the psychological economy of the soldier in combat is a hurried, faulty reaction to opposing stresses complicated by the greatly increased factor of gain in illness. Certainly, there is little difference in the aim of therapy, which is to make it possible for the patient to function with reasonable effectiveness, comfort, and satisfaction on the highest plane of endeavor open to him or forced on him by his life circumstances.

The therapy involved in combat psychiatry and the orientation of the psychiatrist are consonant to the necessities of combat and the type of neurotic reaction that grows out of combat. It is pointless to describe the type of therapy as superficial, or the orientation in shades of dynamism. Both therapy and orientation must be realistic. The psychiatrist, whatever his dynamic persuasion, must orient himself within the prevailing frame of reference, subordinating his particular therapeutic desires to the demands of his mission. Often, he must forego a greater or lesser amount of gratification, depending on how tenaciously he finds it psychologically necessary to cling to his gratifications and securities afforded by the methods of his past therapeutic endeavors. A thorough understanding of personality structure and function is extremely desirable, but no less important is an understanding of motivations, morale, leadership, group dynamics; and a certain flair for decision, teaching, relating to others, and the assumption of responsibility.

A significant development in the Army Medical Service has been the assignment of professional consultants to the staff of the surgeons of major commands. This is not new, but the speed of assignment, the general acceptance of the function, and the utilization of the consultant in the Korean venture are indicative that the momentum generated during World War II has not been lost. The utilization of a consultant enhances coordination of personnel, policy, and action in things psychiatric. Organizationally, psychiatry has been in a position to be effective on a broad scale almost from the very start of this war and, further, the personnel situation with the Army was such that a psychiatrist with

[1] Read at the 108th annual meeting of The American Psychiatric Association, Atlantic City, N. J., May 12-16, 1952.

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broad combat experience was made available for the post.[4]

The American Soldier

An American is in part an expression of his culture. The young man has generally had only vicarious experience in the stern business of sacrifice for the sake of duty, has had little call to live dangerously, and has been pretty well conditioned to regard aggressiveness as an unwonted, dangerous thing. Culturally, he has been indoctrinated into the beliefs that soldiering is impersonal big business, that his individual responsibility to volunteer to protect his country has been assumed by government via selective service, and that his duty assignment really should be more or less in accordance with his civilian training desires. With this occurs a half-formulated belief that his subjective assessment of where and how he could best be used —and, indeed, whether he could or should be used at all—is a correct evaluation. General Hershey has summed this up in his statement that it is difficult to raise an Army when almost everyone feels he should contribute in some way other than by functioning as a rifleman. We see an identical process in some physicians. We can recall one who maintained that he was malassigned; and if memory serves us right, there was one who held he would be of more value to the war effort if he were practicing back in his home town. So much for this self-assessment, which is a real thing and a potent contributor to psychiatric decompensation.

Another concept derived from our culture is the belief that illness relieves a man from obligation and responsibility. This has been conditioned into the American from the cradle on. Early the child finds that illness does relax the family requirements on him; and all through his schooling he finds that the magic of bearing an "excuse" stating that he was sick results in the overlooking and forgiving of his absence. Thus, the whole life experience of the American supports the belief that the production of symptoms, or even the mere presentation of complaints of bodily discomfort, will result in his being relieved of his duties not only with honor but often with sympathy and compassion.

Closely allied to the above is the concept that, despite the fact that people do die, any doctor worth his salt can cure any disease or injury or, at the very least, render any condition asymptomatic so that continuation of discomfort may illogically be held to be the sole responsibility of, and due to the failure of, the doctor.

The above cultural self-serving, self-deceiving concepts account for the oft-repeated statement, "Why sure, Doc, I want to return to duty, I want to fight for my country, but you'll have to cure my back first," which epitomizes the faulty motivation and irresponsibility not infrequently encountered. Such ideas may have a real value in the manipulation of our culture in seeking security in peacetime, but are hardly conducive to contributing to the preservation of that culture by wartime service. Of more value to the soldier and more easily satisfied are his demands for adequate amounts and quality of food, shelter, persons to love and defend, weapons, reward, recognition, leadership, and group belonging, as well as the high ideals and superego values held by the majority of Americans. A modicum of satisfaction in these departments is essential to the functioning of a soldier and, more often than not, is perfectly attainable within the military situation.

That combat itself creates terrific stress goes without saying.

Manpower and Screening

Procurement and selection of manpower is a first step in the formation of any army. Much thought, time, and effort have gone into devising screening procedures. Lists of completely or partly disqualifying diagnoses have been prepared in the assumption that the use of such a screening device would result in the selection of men who would function creditably. We are all too aware that this method is grossly inadequate, that many men inducted under our standards are worthless, while many men that fall far short of the written standard function extremely well. The potential functioning of the individual

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soldier depends so much on his future motivation, associations with others, unit identification, exposure to privation and dangers, and a host of other things that by their very nature cannot be known at the time of the screening examination.

It is high time that we quit thinking that the objective diagnosis necessarily measures function and accept the more difficult responsibility of attempting to estimate function; and failing that, to admit that we cannot, and allow the individual to perform within his setting, until such time as accurate evaluation becomes possible. It is obvious that manpower is a critical item in our country.

I have touched briefly on the fact that the doctor has a little readjusting to do himself. A major reorientation is away from the hoary, false concept that psychoneurotics cannot make good soldiers. Apparently they make just as good soldiers as anyone else, if the pathological and helplessly or aggressively immature personalities are excluded, as has been rather well demonstrated by those who have studied this problem(4). A current readjustment for the neuropsychiatrist lies in intelligent utilization rather than mandatory separation of the medically controlled epileptic who is now acceptable for military service.

The Nature of Combat Mental Disorders

Psychosis occurs in combat as it does anywhere but, as far as is known, in no greater incidence and presents little problem. Evacuation from the combat area, standard treatment, and suitable disposition are provided.

Chronic psychoneurotic reactions present no particular problem either. There seems to be nothing about the neurotic individual that precludes his doing quite good duty providing that the necessary elements of personal motivation, group identification, and good leadership are present. The same may be said of the mentally deficient who function within the limits of their mental capacity.

The character and behavior disorders present the problems peculiar to such personalities, which may be summed up as selfish, disloyal, antisocial activity. Expeditious elimination is indicated.

The emotionally immature seek to evade responsibility, crowd the sick line, but respond better than would be thought to firm handling, leadership, and group dynamics.

And then there is war neurosis. As in the last war, the term combat exhaustion is used within the division regardless of the personal diagnostic belief of the psychiatrist, because it is realized that the minute-by-minute cross-sectional appearance of the patient is often most misleading and that fatigue is an actual, potent factor.

Probably an essential difference between war neurosis and psychoneurosis is the factor of gain. Secondary gain is well known in the neurotic. In war neurosis as in compensation neurosis, the gain is primary, and on a reality basis, although it may be complicated by features of the more classical neurosis. It must, however, be realized that the gain is primary so that the patient may be treated for what afflicts him rather than for something else that may appear morphologically identical. Anxiety and the use of mental mechanisms are common to people, that is, to everyday life, neurosis, and war neurosis, and their presence by no means necessarily spells "psychoneurosis." People particularly vulnerable to the development of primary gain by symptomatology are those currently incapacitated by medical or surgical abnormality who are day-by-day nearing return to combat. The exchange of organic incapacity for the primary gain of war neurosis, as I have defined it, is not uncommon.

What then, of combat exhaustion? This term is an observation diagnosis, designed to take into consideration the factors of fatigue, combat, and exhaustion. Exhaustion implies a potential automatic recuperation. It also relieves the doctor of the necessity of making a premature, perhaps ill-considered diagnosis, eliminating an almost inevitable cross-sectional diagnosis of mental mechanisms, rather than of disease of personality process.

The clinical picture of combat exhaustion is well known and has been elsewhere described in its myriad variations. What is not always so well understood is that its exact symptomatology and timing have a popular connotation: thus the shell-shock of World War I, and the syndrome of having been gassed. Well do we recall a patient from the conflict who had been gassed all right and

painfully incapacitated since he had sat in a damp shell hole containing residual mustard. Twenty years later he was, of all things, still coughing—the popular response! Similarly, under certain conditions, during World War II, 50 missions seemed to be about the time when, if an individual didn't already have operational fatigue, he'd be presumed to get it. In this Korean action, there has been distinct evidence that the magic number of "50" can produce fatigue. These factors are pointed up because they may be overlooked in the face of the very apparent stress of combat.

To oversimplify, the American soldier is caught between his conscious and unconscious desires to perform creditable duty and his conscious and unconscious desires to preserve his life preferably wth honor; and in most Americans honor is prerequisite. In the former desire he is protected by proper food, clothing, shelter, equipment, training, weapons, leadership, group identification, and pride. In the fulfillment of the latter desire, he is protected by the same factors, but also is inevitably consciously and unconsciously aware that survival may be enhanced by leaving the scene of combat, and honor preserved by medical evacuation. Further, most of us are capable of infinite self-deception of the conscious ego through the unconsciously judicious use of the familiar mental mechanisms; and fatigue apparently weighs the balance in favor of such use. That the soldier is continuously at least unconsciously keeping abreast of the possibilities of medical evacuation as a way out of combat with honor is evidenced by his preoccupation with the possibility of being wounded just a little, by his acceptance of ideas favorable to such evacuation, and automatic rejection of ideas to the contrary.

The fact of introgenicity in medicine generally is well known and accepted. In combat medicine, the patient is extremely sensitive to indecision on the part of the doctor, and alert to pick up all or part of any statement he may make that properly twisted may give a modicum of comfort or support complaints psychologically designed to produce environmental gain. Because of the tremendous pressure to better one's lot and chance of survival, logic is sacrificed on the altar of increased chance of self-preservation. Since these things are so it follows that the doctor must take them into his considerations when dealing with patients, realizing that the words he utters do not fall on disinterested ears and that false meanings are apt to be ascribed to his statements. It has been observed repeatedly that the inexperienced physician is prone to make such gratuitous, redundant, and harmful, although seemingly innocuous, statements as, "If you don't feel better, come right back," "There doesn't seem to be anything organically wrong with you, but we'll make some more tests," or "I find you are fit for duty, and do not require further hospitalization, but if you don't feel all right, turn right in to your battalion surgeon." It is apparent what a slight self-deceiving twist will do to such statements. The physician must be firm, decisive, fair, moderate, and brief in his statements. He must not leave decisions conditional on improvement or other action of the patient, because the action then forthcoming will almost invariably be such that further duty appears to be impossible.

Therapy

The factors discussed above as operative in combat fatigue are no less operative in therapy.

The concept developed in both world wars that combat fatigue should be treated as near the scene of combat, and as quickly as possible, is still axiomatic. As far forward in the division as practicable, fatigue is dealt with by proper rest with or without sedation. It is noted that the extent of the use of sedation, while never completely abandoned, varies inversely with the combat experience of the psychiatrist. A considerable proportion of patients make dramatic recovery under such therapy only. Reality values such as the thorough physical examination with reporting on its results and a firm statement of intent regarding return to duty are pointed up. Psychotherapy is brief, indeed, and is best described as an active reflecting, and not entirely nondirective, with focusing on the current problem and summary avoidance of discussion of symptoms and bodily complaints. Rather easily attitudes and feelings, particularly of resentment, hostility, and self-pity, may be elicited, of which the soldier apparently had been consciously unaware,

and which seem to play some etiological role in the decompensation. Such technique is sometimes called repressive. This we doubt. It is more the patient's gaining insight into his use of mechanisms for tremendous short-term gain, but with potentially equally tremendous long-term loss. With just this amount of insight more often than not the ego finds itself able to mobilize resources to react in a fashion more useful in the present and more economical in the long term. When evacuation from the combat zone is necessary, the psychiatrist must forestall guilt by taking on his own shoulders the burden of the decision. Narcosynthesis has been used only infrequently because of the success of other measures. Here again is nothing new. The important thing has been the ability almost immediately to apply well-known principles of combat psychiatric management without having to learn it all over again, the hard way.

As in the last war, the division medical service is backed up by field and evacuation hospitals augmented by the new psychiatric detachment, which, in turn, are covered by station, convalescent, and general type hospitals. The use of direct admission in Japan to a convalescent hospital rather than to a station or general hospital is of great significance in quick recovery and return to duty rate.

It is impossible to present figures to compare our work of this war with the last, because the figures are not easily available to us; and further, current rates and absolute numbers are classified information. It is known that the rate of NP patients evacuated to the zone of interior is tremendously lower than in the last war(5).

Within the division, at present, the return to duty percentage varies from 50% to 90% and varies directly with the absolute number of patients that reach the division psychiatrist. The absolute number varies directly with the dangerous nature of the combat and inversely with the degree of experience of the referring battalion surgeon. The percentage of repeaters has been under 10%. As in the last war, during combat, exhaustion and anxiety are manifested, and during lulls in combat, complaints of bodily discomfort are presented.

In the last few months all divisions have moved their Judge Advocate sections to the forward headquarters so that the administration of justice and disciplinary action can be prompt and on the spot.

The reception of replacements has been vastly improved so that the individual is checked out on his weapons, physically conditioned, and given refresher training at the regimental level. He is received by his company and joins his immediate small group only when that group is off the line and resting. The assignment of a buddy to the new man is Standard Operating Procedure.

Perhaps one of the greatest difficulties in combat psychiatry lies within the physician himself, and this difficulty increases with his personal distance from combat. The physician is the victim of his own attitudes, motivations for the practice of medicine, training, and ego ideal. He often correctly feels that omnipotence is expected of him, and sometimes reacts as though this were true. He finds it easier to speak generally than specifically, and easy to make a decision that a soldier is nervous and should not go overseas or to combat; it is easy to evacuate a soldier from combat and difficult to do the reverse. It is easier to say, "This man should never have been drafted," than to help him adjust to his duties. It is easier to send a frightened young soldier, who reminds one of one's self or one's own son, to the rear than to return him to combat duty. It is difficult to handle the shirker and the malingerer without bolstering one's decision with hostility. One's own feelings of guilt over returning another to combat duty, more dangerous and arduous than one's own duty, make it difficult for the psychiatrist to function effectively and without anxiety. It is quite necessary that the psychiatrist work these things through so that he may effectively and happily carry out his chosen work—or the work that has been chosen for him.

The reasonably well-motivated combat exhaustion patient responds rather well to proper therapeutic handling. The immature and irresponsible at no time perform in a superior manner, but with firm discipline produce an acceptable minimum of performance. The performance of the latter group is contingent on a firm evacuation policy, and the use of administrative discharge by Command carrying with it other than an honorable dis-

charge certificate for those persons who refuse to perform honorable and useful service. The question, of course, immediately arises as to how one can determine who could perform but won't, separating them from those disabled by war neurosis. This question is not easy to answer, but in partial answer, it has been repeated common experience that people will line up to be evacuated medically, but will not flock to receive a blue discharge. All this indicates that most Americans find that they can bear much more anxiety and discomfort than they had believed, if honor requires it. It is not only superego ideas regarding honor, but also good, sound, superficial reality ideas of honor that cause a man to bear anxiety and discomfort in the service of his country.

In the perpetuation of a war neurosis, 2 things are of extreme importance—gain and guilt. The primary gain of removal from danger may be later complicated by financial gain in the way of pecuniary compensation. Such gains may be resolved. However, the burden of guilt that a soldier assumes once evacuated from combat for less than the very best of reasons is an intolerable thing, which the patient may well carry with him the rest of his life to his considerable detriment. We have all had plenty of sad and disheartening experiences in the treatment of NP casualties of the last 2 wars who were the victims of ill-advised evacuation. It may seem unkind to require further duty of a person who is anxious and uncomfortable, but the greatest psychiatric mishandling, and the greatest possible unkindness, is the medical evacuation of a patient who has not yet performed with the degree of honor required of him by both his superego and the community as he sees it, aiding him to burn his bridges behind him and making his guilt irrevocable.

Discussion

The foregoing has been an admittedly incomplete presentation of psychiatry in combat. Neither the problems of the port of embarkation, which approach war neurosis in nature, nor the problem of the more severe, guilt-ridden evacuee, which approaches the classical neurosis, has been discussed. Nor is there space to cover the important forensic aspects or the really excellent and effective use of profiling and assignment that has been developed. This effort has been to call attention to those ideas that have been found necessary to emphasize in the training of medical officers newly assigned to the theatre of war.

Summary

Certain facets of combat psychiatry operative in the Korean conflict have been discussed including American cultural background, psychiatric screening, manpower, introgenicity, motivation, primary gain, the nature of war neurosis, and therapy.

BIBLIOGRAPHY

1. Neuropsychiatry, Vol. X. The Medical Department of the United States Army in the World War. Washington: U. S. Government Printing Office, 1929.

2. Menninger, W. C. Psychiatry in a Troubled World. New York, William Morrow & Co., Inc., 1947.

3. Supplemental Number, The Bulletin of the United States Medical Department, Combat Psychiatry. Washington: U. S. Government Printing Office, 1949.

4. Eagen, J. R., et al. J.A.M.A., 145:7, Feb. 17, 1951.

5. The A.P.A. Newsletter, 4:2, Oct. 1951.

OCCURRENCE OF PSYCHOSIS AMONG OKINAWANS IN HAWAII [1]

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Shortly after the turn of this century the planters of Hawaii turned to Okinawa for the recruitment of plantation laborers. The immigration of Okinawans continued sporadically until January, 1924, when further immigration was abruptly stopped by the Exclusion Act of 1913. The Okinawans in Hawaii continued to live as a fairly distinct minority group in 1947, when these observations were made, making possible some comparisons with the observations of Moloney(1-3) at the time of the American occupation of Okinawa.

Moloney reported a strikingly low incidence of psychotic illness among the native Okinawans, despite years of ruthless exploitation by the Japanese and the dreadful trauma of the Battle of Okinawa. He attributed the psychological stamina of the Okinawans to the "excellent start the Okinawan child gets in life." To use Moloney's words: "He is well mothered." This consists outwardly in keeping the child almost always in direct contact with the mother, even when she is in the fields, and the very free offer of the nipple, with breast-feeding continuing for 2 years or more. After the nursing period, care for the child is usually taken over by an older sibling until he attains sufficient independence to look after himself. These observations led this writer to the hypothesis that the mothering methods of Okinawans should contribute to a low incidence of psychosis among Okinawans in other cultural settings if the same practices continued in the new setting and if these practices were the basis of the freedom from mental illness reported by Moloney. The purpose of this study is to test this hypothesis by observing the frequency of psychosis among Okinawans in Hawaii in conjunction with observations on their mothering practices.

[1] Read at the 108th annual meeting of The American Psychiatric Association, Atlantic City, N. J., May 12-16, 1952.

The author wishes to express his appreciation to Shizu Abe Heau, M. S., for her assistance in collecting material and interviewing informants, to Sarah Counts for the statistical evaluation, and to The Queen's Hospital, Honolulu, for permission to utilize the data collected there.

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INCIDENCE OF PSYCHOSIS IN HAWAII

The author had previously made a study (7) of the racial incidence of mental disease in Hawaii, based on 823 consecutive admissions to the psychiatric division of the Queen's Hospital in 1947. The official population figures of the territory do not distinguish between Okinawan and Japanese; consequently in that study both groups were classified as Japanese. However, it proved to be possible to pick out Okinawans by their names with considerable certainty, using a compilation made by the Office of Strategic Services(4) as a guide. When definite classification could not be made by this means, the patient was counted a Japanese. Population figures used were estimates for 1947 made by the Bureau of Vital Statistics, Territorial Board of Health, based on the 1940 census. Since no separate estimate is made for Okinawans, the figure of 25,000 arrived at in the 1943 O.S.S. study was used. This represents the upper limit of other estimates.

The incidence of nonorganic psychotic reactions distributed according to race is summarized in Table 1.

The rates for Puerto Rican, Korean, and other races are not significant because of the small numbers involved. The rate of 144 psychotic reactions per 100,000 among the Okinawans is higher than the rate for any other significant group and about 2½ times as high as that for the total population. The chi-square test was applied to determine the significance of the number of psychotic Okinawans compared with the expected rate in the total population. This yielded a chi-square of 30.88, which is highly significant for one degree of freedom.

	Expected	Observed
Okinawan	15	36
All others	298	277
$\chi^2 = 30.88$, $p < .001$		(df. = 1, p = .001 if $\chi^2 = 10.83$)

The diagnostic classification used was based on the 1942 edition of the Standard Nomenclature of Disease with definitions from Lewis' Outline for Psychiatric Examination. With these criteria the 36 instances of psychosis among Okinawans were diagnosed as follows: schizophrenia 25, involutional psychosis 5, manic-depressive psychosis 4, and undiagnosed psychosis 2. Okinawans were not distinguished from Japanese in the original study and that the rate of 63 per 100,000 among the Japanese does not vary significantly from the expected rate for the total population is evidence that comparable diagnostic criteria were applied. The conclusion is warranted, therefore, that Okinawan immigrants and their descendants in Hawaii show a higher rate of nonorganic psychotic reactions than any other significant racial group.

TABLE 1

RACIAL DISTRIBUTION AND RATE OF NONORGANIC PSYCHOTIC REACTIONS AMONG 823 PATIENTS ADMITTED TO THE QUEEN'S HOSPITAL PSYCHIATRIC DIVISION IN 1947

Race	Population 1947	Psychotic reactions	Rate per 100,000
Hawaiian and part Hawaiian	77,843	37	47
Caucasian	172,967	69	40
Chinese	30,279	14	46
Japanese (less Okinawans)	146,983	83	63
Okinawans	25,000	36	144
Filipino	54,327	48	88
Puerto Rican	9,546	3	31
Korean	7,216	9	124
Others	1,314	4	304
Total	525,477	313	59

MOTHERING PRACTICES

An attempt was made to collect information concerning the child-rearing practices of Okinawans in Hawaii in the period preceding 1930 (since only 2 patients in this study were under 20 years of age). Three Okinawan physicians with large obstetrical practices were interviewed. Each stated that the Okinawan mother breast-feeds her children as long as possible on the basis of custom, reinforced by a belief that pregnancy is unlikely to occur during lactation. One of the physicians believed that Okinawan parents still practiced the same child-rearing customs as in Okinawa where he had been reared. Another volunteered the information that Okinawan mothers in Hawaii lactate well into the second year after delivery.

Six Okinawan student and graduate nurses were questioned concerning their observations on other aspects of maternal care. They agreed in the observation that the child remained constantly with the mother, even when she goes into the fields, unless there are older siblings. If there are older siblings, the child is often given to their care when the toddling period is reached.

Although this information was obtained by interview and no direct observations were made, the evidence indicates that the practice of prolonged breast-feeding and close maternal contact are similar to those described by Moloney on Okinawa Shima.

Other cultural survivals are evident among the immigrants. Those pertaining to manners, mode of speech, and other general characteristics are sufficiently marked so that Okinawans are distinguishable from Japanese almost immediately by members of either race, although only the most culturally experienced Westerner can observe any distinction. The practice of raising pigs, so prevalent and economically important in Okinawa, has been carried to Hawaii, so that many immigrants established pig barns near plantation camps. That the latter continues, in spite of the considerable social disapproval with which it is accompanied, speaks for the stubborn persistence of cultural institutions among the immigrants.

Most of the Okinawans in Hawaii came from the southern tip of the main island, principally from Naha and the surrounding districts, and were recruited from the poorer classes. The same mode of selection was used with the other Oriental races also, and the rate of psychosis in these does not ap-

proach that of the Okinawans. In regard to the Filipinos, the significantly high rate of 88 per 100,000 is perhaps related to another factor, namely, the ratio of 2 males to 1 female in the population. At any rate, the same selection factors were certainly at work in the Japanese, among whom the incidence of psychosis does not deviate from chance expectation of the total population when the chi-square test is applied.

The evidence presented thus far demonstrates a significantly high incidence of nonorganic psychosis among Okinawan immigrants to Hawaii. There is also evidence that the child-rearing practices among these immigrants relating to breast-feeding and mothering are similar to, if not identical with, these practices on Okinawa Shima. It may be concluded that the hypothesis that the mothering practices of Okinawa should result in a low incidence of psychosis among Okinawans in other cultural settings is disproved.

The Social Setting in Hawaii

An examination of the cultural setting in which the Okinawan immigrant and his children found themselves reveals profound changes from that of their native land. Life on Okinawa as described by Moloney and others was generally simple, unmechanized, and agrarian in nature. Immigrants to Hawaii were faced with regimentation as plantation workers, relatively unfamiliar problems of economic adjustment, and a degree of mechanization highly strange to them. In addition to this they emigrated from a fairly homogenous society to a social setting characterized by rather rigid stratification. In Hawaii they became a minority group in relation to the Japanese, themselves a minority group(6).

Okinawa had been independent of Japan and, in many matters of culture and trade, closer to China prior to the 1870's when Okinawa was incorporated into the Japanese Empire under the program of national unity. While Okinawans consider themselves Japanese and are classified as such in racial groups, they were not accepted by the Naichi, the "insiders" from the main islands of Japan. A study of student papers in the Hawaii Social Research Laboratory(5) revealed prejudice against Okinawans, which is felt on both sides. It appears that this attitude was not well defined in Japan where contact between Japanese and Okinawans was proportionately slight, but became strongly evidenced in Hawaii when Okinawans appeared as a new and fairly large group among the somewhat established Japanese.

The attitudes of prejudice are most strongly evident in the activities of children and when a question of intermarriage occurs. School children commonly tease their Okinawan classmates with the chant, "Okinawan ken ken, buta kau kau," meaning Okinawans eat pig slops. They are accused of being dirty and uncouth; bits of gossip are passed about to the effect that Okinawans wash diapers in the kitchen sink and the like. The Okinawan children complain that the Naichi "take us cheap" or "think they're better than us." When marriage between an Okinawan and Japanese is proposed, there are frequently strong objections, particularly by the Japanese parents, who may in fact disown a son who marries an Okinawan woman. There is evidence that a good number of Okinawans have changed their names to Japanese forms, while the reverse is rarely, if ever, true.

In comparison with other Orientals in Hawaii, the Okinawan seems to be characterized by a sense of inferiority that is often quite conscious. Two outstanding variant personality patterns are seen frequently among Okinawans: one the shy, sensitive, suspicious, withdrawn, "schizoid" personality—the other the strident, pushing, aggressively intrusive, "overcompensating" personality. The prepsychotic personalities of the 25 schizophrenics in this study were variant in one of these patterns. Whether or not these variations are causally linked with social discrimination, the content of the psychotic productions was often related to this problem. For example, a young Okinawan soldier who was sent to Japan developed the delusion that he was avoided because of a bad smell and that the Japanese muttered, "Stink Okinawan" when he passed by them. A 20-year-old Okinawan girl hallucinated hearing remarks passed by her Japanese coworkers to the effect that she was a "no-good Okinawan."

Discussion

These reactions to the depreciated social position of Okinawans seen both in deviations of personality and in the content of psychosis suggest a vulnerability that exists in spite of the mothering practices. It has been assumed that the mothering that children in Okinawa were observed to receive is the basis of their apparent psychological stamina. This may be largely correct when these practices occur in the context of the total experience of the native culture and where the psychological adjustment to be made is defined by that culture. It appears from the present study, however, that these practices carried out in a different cultural context do not necessarily result in the ability to adjust satisfactorily to the new situation.

Summary

This study was carried out to test a hypothesis that the mothering practices of Okinawans afford protection against psychosis in later life. It was found (1) that Okinawan immigrants to Hawaii showed a significantly high rate of psychosis, and (2) that the mothering practices of the immigrants were similar to those of native Okinawans. It is concluded that the hypothesis is disproved.

The social situation of Okinawan immigrants was reviewed. It is suggested that the meaning of cultural practices for personality development should be considered in the context of the total social setting to which psychological adjustment must be made.

BIBLIOGRAPHY

1. Moloney, James C., and Biddle, Charles R. A psychiatric hospital in military government. Psychiat., **8**: 400, Nov. 1945.

2. Moloney, James C. The psychology of the Okinawan. Psychiat., **8**: 391, Nov. 45. (See also Chapter XVI *in* The Magic Cloak. Montrose Press, Wakefield, Mass., 1949).

3. Moloney, James C. On oriental stoicism. Am. J. Psychiat., **103**: 60, July 1946.

4. Office of Strategic Services, Research and Analysis Branch, Okinawan Studies No. 3, 1943.

5. Toyama, Henry, and Ikeda, Kiyoshi. The Okinawan-Naichi relationship: Social process in Hawaii. University of Hawaii Sociology Club, **14**: 51, 1950.

6. Tozzer, A. The Okinawans of the Loo Choo Islands, A Japanese Minority Group. Office of Strategic Services, Research and Analysis Branch, Honolulu, June, 1944.

7. Wedge, Bryant M., and Abe, Shizu. Racial incidence of mental disease in Hawaii. Hawaii Med. J. **8**: 337, May-June 1949.

RELATION OF CIVILIAN AND MILITARY PSYCHIATRY IN CRISIS SITUATIONS [1]

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During both World War I and World War II, and now during the police action in Korea, we have seen dramatic evidence that psychiatry in a military setting can make tremendous contributions to the conservation of manpower and to the preservation of reasonably good mental health among men exposed to severe external stresses. Can psychiatry in a civilian setting provide similarly potent forces to offset the ravaging effects of a major catastrophe, such as an atomic bombing, on the emotional integrity of the civilian population?

Experiences such as those of Dr. Meerloo and investigations such as those of Dr. Tyhurst [2] lead us to recognize certain important analogies between the psychiatric problems presented by the stress of combat and by the impact of civilian catastrophe.

In the first place, both types of experiences subject the participants to hardships far beyond the range commonly experienced by most human beings in the modern world. Insecure as we may feel our society has become, actual death and mutilation are still remote enough possibilities so that we do not live in acute anticipation of their occurrence to us as individuals.

In the second place, similar methods for prevention of untoward reactions seem to be applicable to both military and civilian personnel who are exposed to unusually threatening environments.

Both the military and the civilian groups need awareness of the necessity for enduring the disasters to which they may be subjected. What is known to be unavoidable can be tolerated more successfully than noxious experiences that are thought by the victims to have been preventable by those in positions of authority. Churchill's forthright statement of the need for "blood, sweat, and tears" was psychologically much sounder than Goebbels' subtle distortions.

Both the military and the civilian groups need adequate training and equipment. Absolute immunity against all harm cannot be provided, but techniques and tools that have some protective value will go far toward preventing the utter panic of the totally helpless person in a disaster situation.

Both the military and the civilian groups need competent leaders who can be trusted to translate good motivation and training into reasonably effective action by the group in time of need. While a feeling of individual strength is essential, this feeling requires the backing of group support to be durable. Only good leadership can provide coordination in group response to disaster.

In the third place, the treatment methods that have been developed for military psychiatric casualties appear to have value for psychiatric disturbances among civilians who are involved in catastrophes. Promptness in dealing adequately with the manifestations of internal conflict should keynote psychiatric treatment programs for both military and civilian personnel who are in danger of reacting inappropriately to destructive situations.

In short, it is clear that the experiences of military psychiatrists have potential applicability to civil defense programs. In all fairness, let it be said that some attention has been paid by planning authorities in this country to the analogies that have just been reviewed briefly. Unfortunately, there are certain fundamental differences in the military and civilian programs for defense at present in America. Some of us feel that the implications of these differences are not being faced realistically by the governmental agencies concerned. For the sake of clarity, only one outstanding example of such differences will be discussed.

On all sides we hear complaints about civilian apathy toward civil defense. Does not this apathy reflect a potentially fatal failure in our democratic system of government to face the present situation consistently? On the one hand, we are led to believe that there is such threat to our national

[1] Read at the 108th annual meeting of The American Psychiatric Association, Atlantic City, N. J., May 12-16, 1952.

[2] As reported in papers presented at the same session.

security that military defense requires billions for its support and conscription for its adequate manning. On the other hand, the need for civil defense is presented uncertainly and with little evidence of conviction as to its urgency and high importance. Consequently, many local programs for civil defense have taken on the atmosphere of a spare-time hobby for those with nothing more important to do and a form of occupational therapy for retired generals and defeated politicians. The idea that anyone might be *required* to participate in civil defense has, insofar as one can determine, been given little or no serious consideration. This great disparity between the current philosophy of military defense and the current philosophy of civil defense may very well nullify to a large degree the value of military psychiatric experience for civil defense in America.

Assuming the threat to our national survival to be as great as federal officials indicate, tremendous expenditures for military defense are reasonable. In the light of the same assumption, however, our faltering attempts at civil defense are absurd. One gets the uneasy feeling that our legislators find it easier to buy war materiel than to inconvenience any great number of their constituents. Either the military defense program is excessive, or the civil defense program is tragically deficient. It is obvious that, at present, the 2 programs are not geared to meet the same external threat.

It is true that if we are attacked we must be well prepared to strike back vigorously and promptly. Nevertheless, our initial striking power will dissipate itself rapidly if enemy attacks on critical areas in this country have demoralized the populace to the point where skilled industrial activity ceases. In all candor, it is difficult to believe that the civil defense program as now conceived in this country will contribute very much to preventing such demoralization if we suffer truly major attacks.

Even in a country such as England, where foreign invasions have occurred or have been serious threats many times for many centuries, it was quite difficult to organize an effective volunteer civil defense program before World War II when Hitler's rise to power was obviously leading to war. It then stands to reason that, in America, where actual invasion by a foreign power has never before been a serious possibility, it is almost absurdly unrealistic to hope that volunteer participation will ever provide adequate personnel for the size of job that seems to be involved. We cannot continue to depend on appeals to patriotism and the rather vague fears of the average citizen to stimulate enlistment in civil defense. To do so will only prolong the present serious shortages in trained personnel. Even the efforts of the small minority who are responding to the present appeals will accomplish little.

Consequently, discussion of psychiatric methods for support of the American civil defense program seems somewhat premature, when the program itself is so inadequately conceived that its chances of being effective in time of stress appear to be pitifully small. It is for this reason that the fundamental philosophy of the program is being challenged. Either the job is important enough to be done right, or it should be abandoned lest we be lulled into a tragically false sense of probable security.

How can adequate personnel be obtained? Some form of legally required participation seems unavoidable in America. Such drafting of services for other than strictly military duty would admittedly stir up strong opposition in a country where even a military draft is avoided whenever possible. The magnitude and urgency of the need, however, could be pointed out so clearly to the opposition that they would have to carry responsibility for failure of civil defense measures, if they continued to stand in the way of a civil defense draft.

Actually a country-wide draft would hardly be necessary. The need for civil defense programs is largely confined to the metropolitan areas. Perhaps means could be found whereby earning a living in these areas would be contingent upon registration for training in civil defense techniques and concepts during otherwise free time. Wages and earnings can be taxed for the support of a city. A levy on services for the survival of a city is equally reasonable if the need for such services is great enough. Conscripted trainees could be assigned, in rotation, to various

posts in the civil defense structure of the community. In this manner, no single group of individuals would be expected to carry the entire responsibility for being on call constantly, year in and year out. At the same time a very large proportion of each community would become well enough trained to fit in rapidly to the needs of a disaster situation when summoned by those currently on call when an attack actually took place. Injury and damage sustained during such compulsory civil defense activity could justifiably be compensable by the federal government. Adequate civil defense in target areas is essential for the defense of the country as a whole.

Resistance to a civil defense draft law may well prove to be insurmountable in our American culture. The proposal of such a draft, however, may at least bring out into the open the glaring deficiencies of the present program, and the almost ridiculous disparity that now exists between military and civil defense plans. As long as this disparity continues, one may properly doubt whether our civil defense structure can possibly implement the psychiatric policies that have been found to be so valuable in a military structure.

SURVEY OF NINE YEARS OF LOBOTOMY INVESTIGATIONS[1]

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Studies at the Boston Psychopathic Hospital over 9 years, as well as evidence from the world literature, have carried the conviction that frontal lobe surgery is capable of effecting a rise in the level of adaptation of chronic mentally ill patients. The experience of the Boston Psychopathic Hospital is divided into 2 phases: first, a period of 6 years during which the effect of full bilateral prefontal lobotomy (carried out by Dr. James L. Poppen of the Lahey Clinic and his associates) was studied intensively by a task force of researchers from various disciplines, and second, a period of 3 years, during which the relative therapeutic efficacy of several operations was compared.

A 5-year follow-up of the first 100 cases in our series who received full bilateral prefrontal lobotomy leaves little doubt that the operation is clinically effective. Table 1, for example, compares the changes in work adjustment of 100 patients before illness, before operation (during illness), at 1 to 4 years after lobotomy, and at 5 years after lobotomy. Sixty-six percent of the cases were working satisfactorily before illness. Satisfactory or "good" work adjustment is defined as regular attendance at work. In industry, this implies earning regular wages; in the case of housework, this means carrying out the occupation to the satisfaction of relatives. Psychosis produced a great loss in work efficiency, for only 2% of cases were capable of satisfactory work during illness. Operation, however, released the work potential of many of the patients, with 28% receiving a "good" work adjustment rating at 1 to 4 years and 25% at 5 years. Although postlobotomy work adjustment was not up to the level of adjustment before illness and many patients were lacking in initiative or gravitated to less skilled jobs, nevertheless, the improvement over preoperative level was striking. Furthermore, it is clear that the improvement is sustained over the long run. The same pattern of changes has been noted for mental status, social adjustment, and many other clinical variables that are significant in the assessment of improvement.

TABLE 1

WORK ADJUSTMENT *

	Before Illness		Preoperative		Postoperative 1-4 years		Postoperative 5 years	
	No.	%	No.	%	No.	%	No.	%
Good	63	66	2	2	25	28	20	25
Fair	28	30	16	17	27	30	20	25
Poor	4	4	78	81	37	42	39	50
		100		100		100		100
Unknown	5		4		3		9	
Expired	0		0		8		12	
Total cases	100		100		100		100	

* Percentages calculated on basis of total number of cases for whom information was available.

Although the over-all picture as revealed by the earlier investigations was promising, nevertheless, lack of drive, initiative, and spontaneity; loss of emotional warmth; convulsions, wetting, etc., were specific undesirable effects of the full bilateral operation. Accordingly, the second phase of our studies —*an evaluation of the relative efficacy of bi-*

[1] Read at the 108th annual meeting of The American Psychiatric Association, Atlantic City, N. J., May 12-16, 1952.

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medial and unilateral operations as compared to full bilateral lobotomy on chronic mentally ill patients—was undertaken to answer the question whether the defects could be minimized and the good effects retained or enhanced by less extensive surgery.

Relative Therapeutic Efficacy of the Several Operations

Chronic schizophrenic subjects were allocated at random to 3 operations. There were 35 cases subjected to bimedial lobotomy, 39 cases to bilateral lobotomy, and 42 cases to unilateral lobotomy. Dr. Julius Levine studied all 116 cases before and at intervals after lobotomy. Follow-up studies by 3 social workers of the first 63 cases of this group (an altogether independent analysis in which relatively objective indices of social adequacy were used) lends additional weight to the clinical conclusions. The other studies—psychological, sociometric, and physiological—are more quantitative and detailed, but based only on part of the total series of 116 cases, on patients selected from the larger group because of cooperativeness before operation on the respective test batteries. As will be seen, the major conclusions based on the larger series are supported in essential respects by the more intensive studies.

I. Data from clinical psychiatric evaluation

Taking all operations together, the most striking changes from preoperative level occurred in the categories "tension," and "hostility" (see Table 2). Experience indicates that the operation is specific for high tension, marked hostility, and unpredictable outbursts of violence or aggression.

For all the clinical factors considered, *favorable changes were most marked for the bimedial cases.* Bimedial was outstanding in "over-all improvement," "mental status," "initiative," and "object cathexis." A considerable margin of superiority was manifested in "work adjustment," "social and community adjustment," in relief of "hostility," "disorganization," and "impulsivity."

TABLE 2

Clinical Psychiatric Evaluation

(Based on 116 Cases)

	Type of Operation		
	Bimedial	Bilateral	Unilateral
% cases with marked over-all improvement	37	23	21
% change in "good" mental status	+40	+26	+19
% change in "residence at home"	+31	+25	+14
% change in "good" work adjustment	+28	+18	+14
% change in "good" social and community adjustment	+34	+21	+ 7
% change in "marked" anxiety	−48	−41	−34
% change in "marked" tension	−77	−74	−57
% change in "marked" hostility	−63	−54	−35
% change in "marked" disorganization	−35	−23	−17
% change in "good" initiative	+37	− 5	+10
% change in "good" object cathexis	+34	+16	+15
% change in "good" impulse control	+68	+52	+33

In relief of "anxiety," and "tension," the bimedial operation made a slightly better percentage showing than bilateral and definitely better than unilateral.

The bilateral lobotomy operation ran a good second in most of the categories mentioned. Dramatic improvement was also noted following this operation in the areas of "tension," "hostility," "impulse control," and "anxiety." In this sense, the strong points of both bimedial and bilateral were similar; the bilateral operation, however, was a poor second as regards improvement on "work adjustment" and "object cathexis." Finally, the bilateral operation lagged far behind the bimedial in "initiative." Whereas bimedial was followed by a considerable increase in number of cases showing good initiative, the bilateral operation produced an actual *decrease* in number of cases showing good initiative. The over-all loss in initiative and absence of solid gain in ability to make relationships (object cathexis) helps us to

understand the complaints of relatives that, following bilateral operation, the patients are often lazy, disinterested, lacking in sensitivity and in consideration for others. *It is precisely in the area of initiative that the bimedial cases showed the greatest superiority over bilateral; in the area of "object cathexis," the gains after bimedial operation were at least twice as great as after bilateral operation.*

The unilateral operation ran a poor third. The strong points were again in those areas in which frontal lobe surgery seems to be specific—the tension-anxiety-hostility-impulsivity complex; however, the feeble showing in so many other respects makes it questionable whether unilateral operation is ever worth while in cases with severe chronic illness as compared to bilateral operations. In the single respect of *adding* slightly to the patient's initiative, rather than subtracting, the unilateral was superior to full bilateral, though far behind bimedial.

Before completing the clinical evaluation, data concerning 3 complications should be added—convulsions, wetting, and weight gain. Altogether 17 patients developed one or more convulsive seizures (for the first time in their lives) during the follow-up period. Seven of the 17 either showed some evidence of cortical damage prior to operation, or suffered postoperative complications that could have yielded additional cortical trauma over and above that of the uncomplicated leucotomy. Seven cases had received the bimedial operation, 7 the bilateral, and 3 the unilateral. Although the numbers are small, there is the suggestion that bilateral types of operation carry greater risk of producing convulsive seizures than does the unilateral; perhaps both the bilateral nature of the brain damage and the greater area of cortical damage (in bilateral and bimedial lobotomy) are significant causative factors. Whatever the etiological pattern, taking the data at their face value, the risk of postoperative epilepsy is apparently no greater for the bimedial than the bilateral operation, with the former being superior to the latter in all other respects.

As regards wetting, no substantial difference was noted in incidence of this complication for the different operations, 6 individuals in each group manifesting this symptom at some time in the follow-up period. Weight gain, too, was approximately the same in all the operative groups.

2. DATA FROM SOCIAL SERVICE EVALUATION

Our social workers,[2] independently arrived at the conclusion that patients who received the bimedial operation, after one year or more, were adjusting generally at a higher level than bilateral or unilateral cases. Their "greatly improved" category, for example, was applied only to patients "who took care of their personal needs, fitted harmoniously into the pattern of family or group living, related well to other people, were willing and able to engage in sustained productive activity and no longer demonstrated the problem behavior that characterized the illness period." The percentage of "greatly improved" cases following operation was 53% for bimedial, 27% for bilateral, and 11% for unilateral lobotomy.

3. DATA FROM EVALUATION OF WARD ADJUSTMENT

The adjustment of the patient during the 24-hour day in the wards of the Boston Psychopathic Hospital (both preoperative and 4-6 months postlobotomy) deserves attention. In this approach the milieu to which the patient was adapting was kept relatively constant; it was in every case the hospital environment. A scale developed by Paul Barrabee, Ph. D., attempts to make a quantitative appraisal of ward adjustment. According to this measure, the over-all gains made by the bimedial cases were greatest, unilateral cases were next most satisfactory, and bilateral cases made the least progress after operation.

4. DATA FROM EVALUATION OF PSYCHOLOGICAL PERFORMANCE [3]

The bimedial cases showed definite, though slight, gains in abstraction at 4-6 months and a decided further improvement at 9-12 months postoperatively. The bilateral cases showed slight over-all gains in abstraction

[2] Gladys Madoff, M. S., Sanford Freedman, M. S., and Julian Carrick, M. S.

[3] Dr. A. Meadow, Ph. D., Dr. Dan Levinson, Charles Atwell, M. S.

capacity at 4 months and variable changes at 9-12 months. The unilateral cases showed irregular changes with no clear-cut trends.

5. DATA FROM EVALUATION OF ACTIVITIES IN THE OCCUPATIONAL THERAPY LABORATORY

A. Basic Interaction Units.—According to 1 of 3 observers, Dr. J. S. Bockoven, present in the occupational therapy situation (a social situation permitting freedom of activity), who concerned himself with recording basic units of interaction, the following differences between operative groups were noted. Bimedial cases showed the greatest increase in spontaneity and in motor activity, the most organized and continuous application to tasks, and the greatest increase in neutral affect. (Friendly affect also increased considerably.) Bilateral cases showed the greatest reduction in spontaneity and in motor output. (However, they were more verbal and friendly and showed somewhat greater propensity to be with other patients than either bimedial or unilateral cases.) Unilateral cases were, after operation, least organized in their pursuits, but otherwise relatively inconspicuous in their changes.

B. Interaction Content Analysis; Affect and Productivity.—Observations by the second researcher in the occupational therapy situation, Paul Barrabee, Ph. D., using Bales' categories and supplementary scales developed by him, indicate that at 4-6 months the bimedial cases were consistently higher in desirable traits and lower in undesirable traits than other operative groups. More specifically, they were highest in total interaction, total social adjustment, positive affect, giving and receiving information and orientation, group activity, productivity, and cooperation.

C. The Occupational Therapists' Evaluation.[4]—This disclosed no gross difference between the 3 groups, but only trends that indicated that the bimedial and bilateral cases manifested more socialization in relation to a leader than unilateral cases. The bimedial cases interacted most with the group, and the bilateral and bimedial cases showed greater acceptance of an appropriate shift in task which was requested by the occupational therapy worker.

6. DATA FROM PHYSIOLOGICAL TESTS[5]

In general, the bimedial cases showed in a greater degree those physiological changes we have associated with improvement, namely, drop in resting blood pressure and decreased parasympathetic reactivity. Bilateral cases showed the favorable changes in somewhat lesser degree, and unilateral cases showed the least changes of any of the surgical groups.

SUMMARY

The evidence is strong that bimedial lobotomy is superior in treatment of chronic mental illness to either conventional bilateral lobotomy or unilateral lobotomy. The reduction in anxiety, tension, hostility, and impulsivity is dramatic; the improvement in initiative and ability to form object relationships, the increased capacity to work and to get along, the recession of psychotic symptoms—all were most significant and important. In group situations, patients who received bimedial operation were more interested in interaction, more alive to group needs, more productive and organized in their activities than patients receiving the other operations. Psychological tests suggest that they made definite gains in abstraction capacity. There was no mortality in the total series of cases. The immediate postoperative morbidity of bimedial surgery was no greater than other operations and the incidence of untoward complications no greater than for conventional bilateral lobotomy.

For the present, at the Boston Psychopathic Hospital, bimedial lobotomy has replaced standard full bilateral operation in surgical treatment of chronic mental illness.

[4] Carried out by Barbara Wood, O.T.R., and Dr. Robert W. Hyde.

[5] These studies were carried out by Dr. Dan Funkenstein and Albert F. Ax, Ph. D.

PSYCHIATRY AND HIGHER EDUCATION

Practical Applications of Psychiatry in a College Setting[1]

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The theoretical advantages of close cooperation between educators and psychiatrists are many, and practically no one who has looked closely at the subject would take issue with its desirability. The real difficulty comes in bringing the principles of psychiatry to life on the campus in such a way as to be useful to, and accepted by, students and faculty alike. Certainly many teachers are vitally interested in learning as much from the psychiatrist as possible; it is not so clear that psychiatrists generally have been as willing to learn from educators. To use in an altered form a phrase coined by Sir Henry Tizard, psychiatrists who go into this field "should be as anxious to learn as they are ready to teach."

The psychiatrist on the college campus is not only a student and a therapist; his primary role is that of a teacher. He may only occasionally teach a class or hold a seminar, but every contact he makes influences the climate of opinion concerning the relationship between emotions and learning. Medicine and psychiatry constitute a platform from which he has viewed man in all his complicated relationships to others in society. If education has for one of its aims the thorough knowledge of man—to know a good man when you see him as William James said—then the psychiatrist can compete on even terms with the economist, the philosopher, the historian, or the natural scientist in the attempt to influence favorably the educational offering of the college.

During the last 15 years I have been associated with student health services in which psychiatry has played a very important part. In one institution the enrollment was about 800 and only students were permitted to use the health service; in the other the student enrollment was about 5,000, but faculty and staff members and employees were free to use the service on nearly the same basis as students, all together constituting a community of 10,000 persons. The basic problems faced by individuals in the 2 institutions were very similar in spite of the great differences in their group characteristics. From the psychiatric point of view the opportunity is much greater where all members of the college community are treated alike. For instance, students do not feel embarrassed by seeking a psychiatric interview if they know that faculty members do likewise. Many of the problems presented by a particular professor concerning his students may be related to characteristics of his own personality. A faculty member who has sought and obtained help from the college psychiatrist has a greatly improved attitude about psychiatry and psychiatrists generally, and is usually most helpful thereafter in referring students who have troublesome situations to face. Each faculty member who has had a satisfying relationship with the psychiatric service thereafter helps in establishing a campus-wide awareness of the nature and extent of emotional handicaps.

Possibly the clearest way to show how these principles operate is to describe our own organization at the Massachusetts Institute of Technology. The psychiatric service is made up of 5 psychiatrists; 2 of them are employed on a full-time basis, 2 on a half-time basis, and one, 2 afternoons a week. Patients are referred by faculty members, deans, physicians in the medical department, and, to an increasing extent, by associates who have already been under treatment. During the year 1950-51 there were about 2,500 interviews with 310 different individuals, while in the current year the number is running about 20% in excess of these figures.

The general types of problems resemble those of any private clinic, but there are certain distinct differences due to the selection of students and the pressures under which they work. Since practically all patients have a high degree of intelligence and all of them are of necessity very busy, the

[1] Read at the 108th annual meeting of The American Psychiatric Association, Atlantic City, N. J., May 12-16, 1952.

motivation for improvement is very great. It is a source of constant surprise and pleasure on the part of psychiatrists who participate in this program that patients who seem and are very sick improve so rapidly under treatment. Because of the fact that everyone is so busy, there is no need for occupational therapy; it is already there in abundance.

Owing to the preponderance of patients of a limited age group and of similar backgrounds, certain types of problems occur with greater frequency than in private practice. During each year from 10 to 21 students become too disturbed to continue their studies and are given medical leaves of absence until they are able to return. Permission to resume academic studies is dependent upon approval of the patient's private psychiatrist and our own psychiatric service. Our general policy is to give every person who has been ill an opportunity for another trial unless there are overwhelming reasons to the contrary. It sometimes happens that we readmit a student when we would be much more comfortable not to do so. More often such students surprise us in doing excellent work. We have had several students who have had very serious psychotic episodes, some of many months' duration, who have done excellent work following their recovery. The outstanding example was a student who had a schizophrenic illness of 2 years' duration while in the armed services and received 39 electric shock treatments during that time. After a considerable period of psychotherapy he recovered, entered graduate school, won an advanced degree, and has been quite successful in his professional work for several years. Another student returned to school after a month's hospitalization and did an excellent job of acting in a dramatic club production, the contacts thus made being a good supplement to his psychotherapy. Faculty members who have had mental illnesses have returned following recovery to do very good work. Favorable experiences such as these have served to make the college community very understanding of the problems faced by the student or faculty member who has had a mental illness.

We are cautious concerning the first admission of students who have had a psychosis, but even there we try to decide each case on an individual basis in order that he may not be unduly penalized by his illness. It has seemed to us that, if every educational institution assumes that a part of its function is to help develop an attitude of understanding toward those who have emotional illnesses, the whole problem of taking care of such illnesses will ultimately be lessened. It is impossible to define policies of admission and readmission with precision because each situation must be decided on its own merits. Not only must the welfare of the individual and of the college be considered but strong consideration must be given to the future relationship of the patient to society. One individual cannot be favored at the potential expense of future associates.

It is practically always true that when a psychiatrist becomes attached to the staff of a college he is very soon quite busy with requests for individual therapy. That has been our experience. The method of referral is important. In the beginning the chief sources are apt to be physicians and members of the dean's office staff. As the work becomes better known, an increasing number of referrals come from friends of students who have been treated and from faculty members who have heard about the work.

We believe that contact with the psychiatrist should be as easy and as natural as possible. The psychiatrists' offices should be located with those of other physicians and not set aside in a separate floor or section. Waiting rooms should not be separated. To allay fears of psychiatric treatment I have followed the plan of writing brief articles in student magazines on the role of the psychiatric service. The nature of psychiatric treatment is outlined, the confidential patient-physician relationship discussed, and the student is assured that his psychiatric record is completely private, in our case not even being a part of the general medical record. This has resulted in many students becoming confident enough to ask for help.

In addition to such articles, frequent talks are given by staff members to various student groups and to faculty groups. Each one of these nearly always results in subsequent inquiries about the service or requests for treatment. We make it a policy not to see

anyone against his will unless it is an acute emergency, a disciplinary problem, or some similar situation involving the welfare of others. Even if a student is obviously in need of treatment it is useless to arrange psychiatric interviews until the student's wish to be helped can be utilized.

We have noted that as the psychiatric service has become a fixture on the campus students in large numbers come and ask specifically to see a psychiatrist. Their attitude is in general quite different from the reticence and fear expressed in the usual community.

Although it is necessary to preserve the confidential nature of the relationship between the psychiatrist and his patient, it is desirable to do this in such a way as to avoid resentment on the part of the administrators and faculty members. When a dean or teacher refers a student to a psychiatrist, he is quite naturally desirous of having some kind of a follow-up report in order that he may know what attitude to take in subsequent meetings with the student. In some instances the problem of communication is met by getting the permission of the student to discuss discreetly any aspect of his problem with a faculty member that seems advisable. If the nature of the situation is such that permission cannot or should not be obtained, then the psychiatrist should talk in very general terms with the referring faculty member without conveying any purely private knowledge about the individual. The blunt assertion to a teacher that he can have no information because the relationship is a confidential one serves no useful purpose and often unnecessarily irritates the referring individual. The whole matter can be resolved without harm to anyone if there is confidence in the integrity of the psychiatrist on the part of both the patient and the staff of the institution, and if indirect information is handled discreetly. The teacher who is by nature a gossip can be trusted with practically no information. The discerning teacher can be given abundant background material that will enable him to continue his friendly relationship with the student intelligently while the student is pursuing his treatment.

It would be theoretically desirable if the usefulness of the psychiatrist on the college campus could be independent of his personality characteristics. Unfortunately this is hardly possible. The psychiatrist lets his own work speak for itself, gets involved as little as possible in competitive situations with others in related fields, and keeps his own empire-building tendencies under control. His contribution to the welfare of the campus should sell itself. The desirability of establishing genuine friendly relationships with many persons in the college community cannot be overemphasized. Professors, administrators, faculty wives, town or city officials, the police officers—all can be helpful in the enormous problem of furthering the mental health of the community.

As the educational process in colleges has become more and more complicated, the increasing pressures and duties of faculty members and students have tended to decrease the number of contacts between them. As this tendency has increased, the quality of the teacher-student relationship has also quite naturally decreased. It is a legitimate function of the college psychiatrist to give much thought to the counseling or advising program of the college. The more the psychiatrist can encourage the development of warm relationships between the student and his associates the more likely is the student to develop emotional maturity and the less likely to need professional assistance. In this way the psychiatrist's influence is much greater than if he spends his whole time on individual therapy.

Once there is general agreement in a college that counseling is a legitimate function of the teacher, in importance equal with classroom teaching itself, the question arises as to how the counseling portion of the teacher's job can be improved. Indoctrination probably cannot be accomplished satisfactorily by lectures or by assigned readings. Instead regular group meetings are desirable during which the group devotes itself to the discussion of actual situations and problems that arise. There should be present in each one of these groups someone who is fairly well versed in the counseling process. In many instances this may be a psychologist, a psychiatrist, or someone with similar specialized training. This person should not be there in his professional capacity imparting information, but as another educator working on the common problem. Every pre-

caution should be taken to prevent the feeling that the group is being indoctrinated in any particular discipline or technique.

My colleague, Professor John T. Rule of M.I.T., has given much thought over the past 4 years to the proper function of psychiatry in an educational institution. He points out quite properly that educators have devoted an overwhelming portion of their time to course offerings and only a small amount of energy to the student who is to profit by them. As soon as the teacher becomes interested in motivation of the student, he begins to be vitally interested in the psychiatrist's role in education. To continue in Professor Rule's own words:

> From this point of view his educational function, as distinct from his professional function, is not that of solving emotional problems and curing neuroses but that of clearing the way for learning. It might be stated to be the development of healthy personalities in students in order that they may be capable of achieving the other goals of higher education.
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> But the psychiatrist cannot do this if he is immersed in the traditional doctor and patient framework, for this is an individualized one-to-one relationship. It constitutes the professional side of the psychiatrist's work and only very slightly bears on his educational function. The fact that a psychiatrist in a university has the immediate function of practicing psychiatry on students who need psychiatry is perfectly obvious and beside the point. Similarly, a chemist in an educational institution should, of course, practice chemistry and do research work in chemistry, but this is not the educational portion of his function. It is only a necessary condition to the competent practice of his educational function.
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> Furthermore, the psychiatrist cannot in general be an educator directly for he is not directly involved with the student at the educational level. He can only be an educator in terms of his impact on the capacity of the faculty to become more effective from what he has to offer. The role of the psychiatrist in education is thus, first, the development of an understanding of the importance of the emotions, and, second, the development of competence on the part of educators in handling emotional aspects of education so that they will be capable of developing healthy personalities in their students in order that they (the students) may become truly educated.
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> The problem of the psychiatrist is thus that of stepping from the practice of psychiatry into the role of the educational function of psychiatry. As with any man in a professional field, he must first learn to think as an educator and then to apply his special abilities to the problems of this broader framework. It so happens that his specialized knowledge has a unique content of general importance to all educators. It is in this respect that it differs from that of the chemist. Thus the psychiatrist's main problem becomes the transmission to educators of that portion of his special knowledge that is relevant to all education.
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> In doing this, his first realization should be that he is entering a very broad field with a special understanding, which is only a portion, however important and indispensable, of the entire field.
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> Any new form of specialist, however valuable, is initially in an insular position and quite naturally feared by those who do not understand his specialty. Consequently his first job is to bring what he has to offer into the realm of the familiar in such a way that it is accepted not as a threat to the security of, but as a real aid to, the potential user. Once this is accomplished, he will have created a demand for the generally useful portion of his specialty and may proceed to educate the actual user in its uses. The psychiatrist can thus help the teacher to understand the normal classroom implications of psychiatric theory. Such implications are not obvious and are considerably more than just common sense. They are on the other hand not mysterious and not abnormal. They point up the value of an increased awareness of the subjective mechanisms operating in all human beings. They highlight the importance of the connotations of all behavior as opposed to the denotations of the spoken word in the learning situation.
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> The psychiatrist, however, is in a peculiarly difficult position. He is a highly trained specialist dealing with the abnormal. He operates in an area that creates one of the greatest of human fears, the fear of examining oneself. Thus to the uninitiated he is instinctively taboo, a taboo enforced by the intense human hostility to the occult, the mysterious, and the unknown.
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> Furthermore, the psychiatrist himself is caught in his own trap. Breaking into a virgin field that has advanced with great rapidity, he inevitably feels that he belongs to a group that is at long last unlocking the secrets of human personality. He thus belongs to a priesthood carrying a torch and he develops all the insularity common to an esoteric group—the special vocabulary, particularly the special meanings for common words, the instinctive tendency to discount the viewpoint of the uninitiated, and the gradual unconscous immersion into a group mores, a special frame of reference that sets him apart from outsiders.
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> The latter is not unusual. All groups display it. Physicists or professional ball players exhibit exactly the same phenomenon. In these instances it does not matter. But with the psychiatrist it does matter, for it sets him apart from the very world into which he must at all costs be accepted.[2]

A widespread but erroneous idea is current in some colleges, as among the public generally, that psychiatrists are too permissive in their attitudes toward patients. Those who have this idea think that the student

[2] Personal communication.

goes to the psychiatrist to get out of something, and that any shortcomings he may have will be overlooked and excuses found for him. This concept is furthered when a faculty member notices that a student is in a jam and is handled by medical means rather than through disciplinary channels, especially when he does not know the reasons for such exceptions. Here again the problem of maintaining confidences shows itself, and it is up to the psychiatrist to convey some information to the faculty member that will cause him to believe that the situation is being handled fairly without telling specific details of that particular student's history.

The college psychiatrist does maintain a "permissive" attitude toward his patient as an individual, listening to him carefully, passing no moral judgment, and helping him understand his own emotions and behavior precisely as he does in any other therapeutic relationship. As an individual, however, he strives to maintain the highest possible standards of ideals and behavior on the campus. With his patients he seeks satisfactory solutions to their problem within the existing framework or codes of behavior, with a minimum of exceptions, and with no opportunity for the patient to obtain secondary gains from his illness. He helps the student formulate and understand the struggle he must make to achieve maturity and independence and the ability to make wise decisions.

When the university as a whole interprets its policies in such a way that standards are imposed gradually, by public opinion in so far as it is possible, and by specific administrative pressures when necessary, and with prime consideration for the needs and previous experiences of the individual, then the student is more likely to feel that the basic environment is friendly even if he is occasionally in conflict with it. If rules and regulations are enforced rigidly and impartially, with little consideration for the individual, the student has sufficient reason, from his self-centered narrow viewpoint, to blame the institution for his own inadequacies. A genuine attitude of understanding on the part of teachers and administrators, together with slow steady firm pressure toward the maintenance of mature attitudes, is a factor of great strength in the institution. The college psychiatrist is in an ideal position to further true concepts of the role of psychiatry, both in its therapeutic and social aspects. By making known the real nature and goals of psychotherapy his contribution is especially effective.

A major need is the establishment of several training courses in the application of psychiatry to education. Several universities have developed programs sufficiently advanced to permit the addition of two or more fellows in training for periods of at least a year. The most suitable time is just at the completion of requirements for the American Board of Psychiatry and Neurology. This necessitates a financial return sufficient to permit a reasonable standard of living for the psychiatrist and his family. Some of this cost can be borne by the institution giving the training, but some of it must be borne either by the college or university for whom the person is being trained or by some foundation interested in mental health and education. In this area lies an opportunity for a foundation to make a major contribution at much less cost than the usual research project.

During one year of my time in educational institutions I had occasion to serve as Dean of Students in the interim between the accidental death of the permanent Dean and the appointment of his successor. Aside from acquiring a great deal of specialized knowledge of the curriculum and how students meet its requirements, I found the experience in psychiatry to be very useful for the problems encountered in that office. Some of the personal problems were of such an intense nature that immediate referral to my psychiatric colleagues was in order. Others could not be referred, either because of lack of time on the part of the psychiatric service or of unwillingness on the part of the student or his family to accept psychiatric help. Occasionally some amusing incidents occurred as a result of my unconventional background. On one occasion I had been seeing a first-year student who was moderately depressed, who blamed his mood changes on his living conditions. He changed them without any benefit to his state of mind. In a subsequent conversation with his mother, who showed much appreciation for my interest in him, she asked that I be sure that no psychiatrist saw him. When I informed

her that he had been doing so already, her attitude gradually became more accepting and her son withdrew from school and accepted psychiatric treatment.

As a result of working directly as an educator, I became convinced that the psychiatrist has much to contribute to the educational planning of the college if he thinks in terms of the problems of the entire institution, supplemented by his experiences in treating the individual problems of disturbed students. To do treatment of sick students exclusively, or to work only through others on general problems, is to restrict sharply one's opportunities. Each experience reinforces the other.

In reviewing the entire field of the role of psychiatry in higher education it is quite clear that emotional problems of students are numerous and often severe, that individual therapy is always in demand, and that positive programs are needed to help develop emotional maturity parallel with intellectual maturity. In fact there should be no separation and maturity should presuppose both components. The unsolved problems are many and difficult. Awareness of the problem on the part of colleges and universities is gradually developing and is being expressed in requests for help and suggestions from those who have no psychiatric services. Too few psychiatrists are interested in this field. Training opportunities are limited. The responsibility of an educational institution for the emotional component of education is not clear to many, and there is sharp debate about financial responsibilities.

That it is a field of vast opportunities for the psychiatrist is readily conceded. Those of us who are in it find it stimulating and rewarding. The chance to cooperate with so many other fields of learning is hard to duplicate in other settings. The college psychiatrist needs to supplement his professional knowledge with wide reading in literature, philosophy, and art as well as the social sciences related to psychiatry. This is not to say that he must become a specialist in these other fields; instead he needs to acquire a broad background of knowledge that will enable him to combat the evils of specialism, including his own. A young generation of psychiatrists, possessed of sound training, social vision, and great capacity for growth could further the interests of psychiatry and mental health more advantageously and quickly in this field than in any other. The attitudes developed in college soon become those of the young community leaders all over the nation. The college psychiatrist is in a favorable position to help make those attitudes responsible and mature.

DRUG ADDICTION IN RELATION TO PROBLEMS OF ADOLESCENCE [1]

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The recent wave of heroin addiction among adolescents has focused a great deal of attention on both the problems of drug addiction and the problems of adolescence. Michael J. Pescor's statistical analysis(1) of 1,036 drug addicts admitted to the United States Public Health Service Hospital at Lexington, Kentucky, between July 1, 1936, and June 30, 1937, reveals the interesting fact that 16.5% started their addiction before the age of 20, 44.8% before the age of 25, and 69.7% before the age of 30. Only 3% started their addiction after the age of 45. Two individuals started the use of drugs at 11 years of age, and 1 at 12.

Statistics from the psychiatric division of Bellevue Hospital reveal that between 1940 and 1948 no patient under 21 years of age was diagnosed as a narcotic addict. During the year 1951, 371 adolescent drug addicts were admitted. This figure breaks down according to sex into 282 males and 89 females, and according to age as follows:

14 years—10	18 years—72
15 years—30	19 years—77
16 years—51	20 years—62
17 years—69	

These figures are not an absolute index of the extent of the increase of drug use among adolescents in New York City because during the year 1951 the hospital modified its policy and opened its doors wide to these youthful addicts in the face of a social and medical emergency. However, these statistics are undoubtedly reflective of a marked increase.

Pescor's statistics point up the fact that drug addiction in adolescence is not a new phenomenon and moreover that opiate addiction primarily involves adolescents and young adults. The Bellevue statistics indicate that drug addiction finds a fertile soil among adolescents.

In New York City, where the wave of drug use among adolescents in the United States reached its highest peak, many conferences were organized by public and voluntary agencies to study the problem, to pool information and to draw up plans of action to eradicate this evil(2-4). There was general agreement at these conferences that the problem was complex and multifaceted, involving sociologic, economic, and psychiatric determinants. There is, for example, a probable relationship between war tensions, the emphasis on destruction, the fear of atomic attack, the inevitability of military service interrupting efforts of young men for the future, and a feeling of ephemerality, a living from day to day, a quest for momentary pleasures, and the relaxation of constructive and responsible activity that constitutes an important part of adaptation toward adult status. Most of the adolescents interviewed on our service, when asked what their plans for the future are, state that they plan to join one of the branches of military service. This response does not derive from a sense of duty or an understanding of international issues, but from a wish to escape from sustained and responsible activity.

There is also a correlation between poverty, social degradation, racial discrimination on the one hand, and delinquency, poor scholastic performance, and drug addiction on the other. It has been our impression that actual social deprivation magnifies feelings of emotional deprivation that may have had their origin in family relationships. During the period of adolescence, when the emotional and sensual appetite is enormous, we find a condition of "affect hunger" marked by strong drives to encompass the world of sensations and experiences.

It is an obvious fact that, if drugs were not available, we would have no drug addicts and that, conversely, in those sections of the city where drugs were "pushed" on to the

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[1] Read at the 108th annual meeting of The American Psychiatric Association, Atlantic City, N. J., May 12-16, 1952.

From the Psychiatric Division of Bellevue Hospital and the Department of Psychiatry, New York University College of Medicine.

youth by desperate and unscrupulous peddlers the incidence of drug use by adolescents was greatest. However, there is still the question of why, under apparently similar external conditions, some boys will try the drug and others won't, why some go down the road to addiction while others give up the drug or become "joy poppers" or "weekend users," and why some boys stay with marijuana while others go on to heroin.

The factor of curiosity can only explain the initial experimentation with the drug and cannot account for recidivism after a "withdrawal cure." Theoretically, anyone can become chemically addicted to the opiate, including embryos in utero and primates in the laboratory. But only the human being, or rather certain types of human beings, will return to the enslaving, self-destructive habit after a "withdrawal cure." It appears that, after such additional factors as cultural and accidental experiential influences are considered, there remains a large psychologic factor in drug addiction.

The Heroin Addict Type

Very early in our study of adolescent drug addicts we were impressed by the fact that these boys had several personality characteristics in common, and we reported our findings in 2 preliminary papers based on the study of 22 and 36 boys respectively (5, 6). Since then, we have studied a total of 65 such cases, and our initial impressions were largely confirmed and deepened. At this time we feel we can delineate among adolescents a heroin addict type. Persons of this type have the following characteristics:

1. They are essentially nonaggressive, nonimpulsive, soft spoken, and verbally adept. They show a superficial ease, grace, and maturity in their interpersonal relationships. They give the impression of great sincerity. They are not typical gang boys and delinquents. The great majority of them have no court records for delinquency prior to their addiction. This observation is in accord with the findings of Pescor, in the statistical study cited. He found that three-quarters of his patients had no delinquency history or record prior to addiction.

2. They are conservative in their tastes, intolerant to conflict, noise, raucous music, and ostentation in dress and behavior.

3. They have a very close empathic relationship with the mother or mother surrogate. They are frequently the mother's favorite; the father is usually out of the picture because of death, separation, or lack of emotional rapport. Not one of this group had a history of institutionalization during childhood, or frequent placement changes, or shifting mother figures. There was always a history of a sustained relationship with the mother figure. However, there was no evidence of morbid dependency on the mother.

4. Their interpersonal relationships in general are tenuous and readily given up, especially under the influence of the addiction. However, they retain a close relationship with one or two other youthful addicts, whose personalities are similar to their own, and with whom they spend most of their time. In their fantasies, they always exclude the father, sometimes include the mother and sisters, and almost always include their one or two addict friends.

5. Many of these boys used marijuana prior to their heroin addiction. While most of them stated they liked marijuana, it was not an unmixed liking. Under marijuana they were much more impulsive, outgoing, and sexually aggressive, and they were also much more anxious. They stated that, after the effects of the marijuana wore off, they felt uneasy about their behavior, they were ashamed of themselves, and felt like "damn fools." Several boys describe paranoid reactions under marijuana amounting to hallucinosis. They all prefer heroin to marijuana.

6. All these boys show profound work and school inhibitions, a fear of new situations and tasks calling for active mastery, and difficulty in initiating aggressive activity. One boy who had had some success in amateur boxing lamented the fact that he could never get himself to throw the first punch. Scholastically, they all function below their intellectual potential. In school it is difficult to to get them to undertake an assignment and they will finish it only with a lot of prodding. On the ward they displayed incredible inertia, laziness, and boredom. Three to 4 weeks after admission they were still a study in slow motion, so that their inactivity could not be attributed to the chemical effect of drugs.

We referred 7 of these boys to a voca-

tional advisory service for guidance and job placement. Six of them were typical of our group; the other boy had been taking heroin in moderate doses and came into Bellevue Hospital with a schizophrenic reaction. After an interview with this boy we decided he did not fit into our group, mainly because he appeared to be oriented toward activity. He went out on his first assignment by the Vocational Advisory Service, obtained a job, and has been working there since. None of the others pursued any of the job leads. One of them kept his appointments with the agency worker until a definite job prospect was obtained, when he suddenly dropped out of sight.

7. From their statements it appears that most of the boys have had some heterosexual experiences. They seem to have less difficulty discussing sexual matters than the average boy. None of them expressed negative attitudes toward heterosexual relationships, as boys often do. However, they did not give the impression that they engaged in sex with any real zest. They placed the emphasis on the accomplishment, and on the competitive basis of being more successful than other boys. Practically all of them lost their sex drive during their addiction, and none of them expressed any concern about this. They were prepared to give up girls and sex as long as they could get heroin.

8. All the boys described a similar subjective experience under the influence of heroin, consisting of (a) a disappearance of anxiety and a feeling of euphoria with a sensation of buoyancy or floating, (b) increased self-esteem and self-confidence with a feeling of positiveness consisting of the conviction of seeing in a situation all the pertinent relationships necessary for a correct solution, and having the ability to carry out the acts leading to that solution, (c) fantasies of omnipotence in the possession of great wealth and power, usually by virtue of owning huge supplies of heroin. Sex and actual acts of achievement are absent in these fantasies. In actuality, under the influence of the drug, judgment and performance are impaired. They resent the intrusion of any reality that challenges these illusions of omnipotence and as a consequence isolate themselves in order to preserve them.

Psychological Picture

The patients were all given a battery of tests including one of the Wechsler-Bellevue Intelligence Scales, educational achievement tests (Woody McCall Arithmetic Fundamentals; Gray Oral Reading Paragraph or Monroe Silent Reading Tests), a word association test, human figure drawings, the Wertheimer Gestalten, and the Rorschach test.

The intelligence level ranged from borderline to high average, the mean being dull normal. In this respect they conformed to the intelligence range of the other boys on the ward. As is true for most of the adolescents on the ward, these boys showed considerable inter- and intratest variability. This indicates that they cannot make adequate and efficient use of their mental resources because of emotional conflicts that interfere with their functioning.

Though the subtest patterns obtained on the intelligence test did not yield a clear-cut and consistent profile just for this group, some common trends were discernible that are characteristic for them as a group and are also substantiated by findings on the other tests. These are:

(a) A general constriction of interest, which results in an inability to absorb adequately what is offered through the school and cultural environment.

(b) Drive and energy tend to be inhibited or misdirected. Though these need not be abolished altogether, they are not channeled into useful and achievement-furthering activity.

(c) They can adjust more easily to tasks and situations demanding passive attention and alertness than to those that require a a more concentrated effort and independent ideation of a creative nature.

(d) In line with (c), there is the trend toward dependent thinking and judgment. They generally show a front of conventional social judgment.

(e) They also show a certain ease in manipulating—on a superficial level—practical social situations that are structured, more familiar, and not deeply ego-involving.

(f) They are, however, concrete and egocentric in their reasoning. Narcissistic features are marked. When they are confronted

with more pressure or less structured situations, or when they are more involved, they show also disturbances in mental control and deviation in thinking. Schizoid traits, often with paranoid features, were elicited in varying degrees. Such disturbances were mostly associated with low frustration tolerance.

The educational achievement test results indicate that these boys—like most others coming to the ward—are generally retarded in their basic subjects.

The personality picture revealed by the projective tests was again not a unique one. However, there were certain group characteristics. It is true for most of our disturbed adolescents on the ward that their ego development is extremely weak, so that they are unable to deal adequately and in a self-satisfying way with inner conflicts and the outer reality. Immaturity in their emotional development and in their inner life, with a tendency to follow their more primitive drives, is another common phenomenon. A rather striking distinction, however, between these boys and other delinquents is found in their handling of emotional impulses, their aggressions, and their general reaction to environmental stimuli. In the other delinquent group we find the tendency to overt aggression, expression of hostility and negativism. The drug addicts, on the other hand, show greater conflict about their emotional impulses and they tend to experiment more with all kinds of defensive mechanisms. They react with repression, inhibition, constriction, denial, evasiveness, reaction formation, or projection. Some also show a tendency to rationalization, intellectualization, and compulsion. In general, anxiety is easily evoked in this group, and they have the tendency to avoid anxiety-rousing situations. In the face of an unstable and weak personality make-up, their attempts at control are not very successful. They show breaks in rational control and disturbance in reality testing from milder to more serious forms. They do not usually react with overt aggression and impulsivity. There is a strong tendency to detachment and withdrawal into private fantasies of omnipotence, grandiosity, and striving for recognition. In spite of the fact that they appear on the surface socially oriented, they give up realistic goal strivings in favor of indulging in pleasure strivings. There is also evidence that this group, under the impact of strong emotional challenge, tends to display a rather morbid type of body preoccupation. Their feelings of inadequacy and weakness extend to the problem of body image. If interpersonal and general reality situations become too threatening or frustrating, they withdraw to the narcissistic level of adjustment. Genuine object attachments cannot be maintained.

The question of identification and status is a common problem in most adolescents. The self-picture of these boys is one of inadequacy, confusion, and impotence. They need support in a passive, dependent relationship. They show a particularly strong mother attachment. But this also seems to create a great deal of conflict and anxiety. They give the impression that they are not fully satisfied in this relationship. The mother figure is also viewed with fear and frustration.

Sexual conflicts are indicated. Usually the sexual drive is given up and denied. They may show acceptance of their masculinity, but heterosexual strivings are usually repressed. Homosexual trends are usually discernible. In some instances these are more pronounced and they use this type of peer-relationship and attachment as a means of attaining affective gratification they do not seem able to obtain otherwise.

The Adolescent's Problem

In view of the recent outbreak of heroin addiction among adolescents, the fact that a large proportion of addicts started their use of opiates during adolescence and young adulthood, and the type of personality problems presented by the young addict, we feel that opiate addiction in these cases has some relationship with the problems of adolescence.

Adolescence is an important period of maturation, marked by an accession of strong sexual drives, by a growing social awareness, and by the necessity for a psychosocial reorientation. In the male adolescent, the strong sexual drives and the necessities of his socio-economic situation impel toward

the assumption of an adult masculine identification and role in life. This need does not arise *de novo* at this period, but at this period decision as to the role the adolescent is going to play becomes more imperative.

The incest goals of the sexual drives reinforced by the social attitudes toward sex, particularly as they are transmitted through the parents, impose difficult problems in the path of an assumption of the desired role. The adolescent perceives his activity, partially motivated by his sexual drives and goals, as a threat against his parents, and therefore dangerous to himself. Anxiety being a psychophysiological response to the perception of danger, many of the aspirations and activities of the adolescent are attended by anxiety. The manner in which he handles these aspirations and anxieties is dependent both on his past experience and on his present situation. When his relationships have been, in general, wholesome, he will eventually make a successful adaptation. Where his relationships have been injurious, he brings to the task at hand distorted conceptions and convictions and inadequate and self-defeating mechanisms. Similarly, if his life situation is favorable, he finds greater encouragement and motivation to undertake this task, which he considers hazardous, and when the situation is unfavorable, the neurotic barriers are reinforced.

It has been observed that adolescence appears to be a mixture of apparently incompatible opposites. Shyness, awkwardness, boredom, depression, and withdrawal are expressions of inhibited activity. Brashness, enthusiasm, impulsivity are facilitated activity. Feelings of unworthiness, inferiority, and inadequacy are in contrast to grandiosity. Positiveness is opposed to indecision, rebelliousness to submissiveness and the need to conform, hero-worship to iconoclasm, and so on. Many of these symptons and patterns are the consequences of the problems of making the transition from childhood to adult status. This bipolarity of behavior in adolescence can be considered an expression of the indecision of the adolescent as to whether he is going to be an adult or a child, a sexual man or a castrated man. The confusion in sexual identification that is found almost universally in the psychological tests of adolescents is also an expression of this indecision. A boy does not have problems primarily because he is confused as to whether he is a boy or a girl. But because of the problems he sees in assuming the adult masculine role, because of real and imagined difficulties and dangers, he cannot make the choice, or he fluctuates between one choice and the other, and tries to make some compromise decision. Similarly, we do not believe that in most cases individuals persist in immature relationships because of a deep yearning for the mother, but only as a safer alternative to, and escape from, mature, responsible, and sexually adult activities.

Adolescence is also a period when social horizons begin to extend beyond the family, the school, and the immediate neighborhood. It is a period when social relationships and attitudes become greater and more personal realities; when social discrimination, poverty and caste systems, lack of opportunities, unemployment, competitiveness, contradictions between moral teachings and social practice become personal problems and obstacles to the assumption of the adult role. They reinforce feelings of inferiority and inadequacy, and they frustrate the needs for mastery and love.

This is a very general statement of a critical problem of male adolescence, as we see it. There are many ways in which adolescents attempt to deal with this problem. The actual methods employed depend upon a complex interaction of basic personality patterns and relatively fixed and accidental environmental factors. Narcotic addiction can be considered one way of handling the problem that fits the needs of the type of boy that we are dealing with.

This is the type of boy who perceives his activities as so dangerous that he has a strong need to inhibit all of his aggressive and sexual impulses (7). He can find peace only under the influence of the drug, when sexual appetite is gone, and all aggressive activity is suspended. Then he can engage in his pleasurable fantasies of omnipotence. Even in these fantasies there is an absence of conflict, of active achievement, and of sex. There are just wealth, power, a potential capacity for achievement, and passive pleasure by virtue of owning huge supplies of heroin.

The aggression that he inhibits is not primarily hostile aggression. This type of boy does not appear to have a special problem of hostility. It is the general type of aggression that has to do with dealing actively with the environment, with active mastery, creativeness, accomplishment, planning and building for the future, and of responsibility. In effect, it is the activity characteristic of maturity, and the relative freedom from neurotic fears.

SUMMARY

1. Statistics are cited indicating that drug addiction in adolescents is not a new problem and moreover the opiate addiction involves primarily adolescents and young adults.

2. The problem of heroin addiction is complex and multifaceted involving sociologic, economic, and psychiatric determinants. After all other factors are considered there remains a large and constant psychological factor.

3. A heroin addict personality type among adolescents is delineated and its characteristics are discussed.

4. Drug addiction in young people is related to the critical problem of adolescence, that of making the transition to adult status and responsibility.

BIBLIOGRAPHY

1. Pescor, M. A Statistical Analysis of the Clinical Records of Hospitalized Drug Addicts. Supplement No. 143 to the Public Health Reports. United States Government Printing Office, Washington, 1943.

2. Conference on Drug Addiction among Adolescents held at the New York Academy of Medicine, November 30, 1951, sponsored by the Committee on Public Health Relations of the New York Academy of Medicine, with the assistance of the Josiah Macy, Jr. Foundation. Not for general publication.

3. The Menace of Narcotics to the Children of New York: A Plan to Eradicate the Evil. Welfare Council of New York City, August, 1951.

4. Narcotics. A Report by Nathaniel L. Goldstein, Attorney General, to the Legislature of the State of New York, January 14, 1952.

5. Zimmering, P., et al. Heroin addiction in adolescent boys. J. Nerv. and Ment. Dis., **114**: 19, July 1951.

6. Toolan, J., et al. Adolescent drug addiction. N. Y. State J. Med., **52**: 72, Jan. 1952.

7. Bieber, Irving. Pathological boredom and inertia. Am. J. Psychother., **5**: 215, Apr. 1951.

DISCUSSION

ABRAHAM WIKLER, M.D. (Lexington, Ky.).—The results of our studies on adult addicts at the U. S. Public Health Service Hospital in Lexington, Kentucky, are in general agreement with the findings reported in this paper. Drugs that are preferred by adult addicts, namely, opium and its derivatives, meperidine and methadone, all possess in common the properties of reducing or gratifying certain "primary" needs, such as hunger, sexual urges, and fear of pain. They also promote fantasy living and permit the user to express aggressiveness and hostility in daydreams characterized by feelings of omnipotence and "luck," rather than overtly. This is in sharp contrast to the effects of barbiturates, alcohol, marihuana, and cocaine. In general, these agents do not gratify such "primary" needs directly; indeed, they may intensify them. However, the drugs in this class impair repression and allow the user to "act out" impulsively and to gratify his needs through such behavior. Opiate addicts may use drugs of the marihuana-alcohol type when supplies of morphine or heroin run low, but they prefer the latter. The choice between one or the other type of drug seems to be related to specific personality characteristics, which in part are culturally determined. However, they have not been delineated clearly. Perhaps light may be shed on this problem by studying the psychodynamics of alcohol addiction in individuals who have experimented with opiates, but have given them up in favor of alcohol.

The habitual use of drugs to achieve "euphoria" (or, as the addict terms it, "a high," "pep," or "drive") is *prima facie* evidence that the user has not been able to achieve this eminently desirable state through interpersonal relations of a socially acceptable type. This is borne out by psychiatric studies that indicate that the great majority of narcotic addicts have "abnormal" personalities. However, in the case of adult addicts, it has not been possible to determine whether such "personality defects" existed prior to addiction, or were the consequence of this process, or whether they differed significantly from those of nonusers of drugs. The current interest in "juvenile addiction" offers an opportunity to investigate this important problem. Dr. Zimmering and his colleagues apparently have concluded that the personality defects related to addiction antedate the addiction process. The general psychologic problems of adolescence are shared by juvenile addicts, but they handle them by withdrawal, narcissism, and dependence, and this process is facilitated by the use of heroin or other opiate-like drugs. This seems to be a very reasonable conclusion, but I would also like to add that the addiction process itself alters the individual still further, and that the psychologic changes associated with continued drug use are longer lasting than the physiologic changes.

I am aware that in previous publications the Bellevue Hospital group have minimized the extent of "physical dependence" among juvenile addicts, and that they have regarded such "withdrawal signs"

as they do show as "psychogenic." If by this term is meant that the intensity of abstinence phenomena is mild among juvenile addicts, and that they vary considerably in different observational settings, I can agree with them in part. However, current studies on juvenile addicts in Lexington have indicated that the majority of such individuals who have used narcotics in the recent past have developed a definite degree of "physical dependence." This has been determined by 2 methods: (a) direct observation immediately after admission before administering medication and (b) the administration of single doses of N-allylnormorphine to patients who showed no clear-cut signs of "physical dependence" immediately after admission. We have demonstrated in other studies that 15 mg. of N-allylnormorphine regularly precipitates acute "abstinence phenomena" in postaddicts who have been experimentally addicted to as little as 15 mg. of morphine 4 times daily for one week, 10 mg. of methadone or 15 mg. of heroin 4 times daily for 3 days; and after more prolonged addictions, the subcutaneous administration of as little as 2 mg. of N-allylnormorphine may precipitate severe "abstinence phenomena" in such individuals. Similar findings have also been obtained in studies on the actions of N-allylnormorphine in chronic spinal dogs who have been addicted to morphine for as little as 2 days. These data, and the earlier demonstration in our laboratory that clear-cut "abstinence phenomena" can be produced in chronic decorticated and in chronic spinal dogs after a period of addiction to morphine or methadone, constitute strong evidence that the genesis of the opiate abstinence syndrome is in large part related to factors of little or no symbolic significance. The role of "physical dependence" in the self-perpetuation of the narcotic addiction process and in recidivism is an important one, but cannot be discussed in detail here.

Our studies on juvenile addicts are still in progress, and aside from the facts already stated we have not yet drawn any final conclusions.

TREATMENT IN ALCOHOLISM

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PART I

RESULTS OF THE TREATMENT OF DELIRIUM TREMENS WITH ADRENOCORTICAL EXTRACT

Following the reports of Tintera and Lovell(11) and Smith(8), regarding the beneficial effects of adrenocortical extract (ACE) and adrenocorticotrophic hormone (ACTH) in the treatment of chronic alcoholism, 8 patients with delirium tremens were treated, using adrenal cortical extract in an attempt to evaluate its effectiveness in decreasing the morbidity in delirium tremens.

Tintera and Lovell(11) postulated that hypoglycemic periods in alcoholics lead to a craving for alcohol. The consumed alcohol caused an initial hyperglycemia, followed shortly by a hypoglycemic state that required more alcohol to repeat the cycle. Eventually the liver glycogen is depleted, fatty infiltration ensues, and liver function is proportionately decreased. Although it is not mentioned, it is generally accepted that in some patients repeated episodes of fatty infiltration eventually lead to cirrhosis.

The authors state that the "entire process" (presumably from hypoglycemia to fatty infiltration) is reversed by the administration of ACE, "which mobilizes glycogen from tissue protein, increases the blood sugar and initiates a return toward normal functioning of the liver." It is then concluded on the basis of clinical and laboratory observation and "satisfactory therapeutic results" that a state of hypoadrenocorticism exists. It was further found that sedation was usually unnecessary because the ACE produced a "sensation of warmth and relaxation." Other adjuncts besides ACE used in the treatment program included association with Alcoholics Anonymous, insulin in those with anorexia, and testosterone in those with evidence of testicular atrophy.

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A report by Smith(7) describes alcoholism as a metabolic disease on the basis of laboratory and clinical findings. The similarity of the biochemical and laboratory findings in delirium tremens and Addisonian crisis is pointed out and is the rationale for the treatment of chronic alcoholism with ACE and ACTH. In a later paper Smith found ACE to be more effective than ACTH in the treatment of Korsakoff's syndrome and acute alcoholism; he also stated that ACE has a more prompt sedative action than ACTH. However, ACTH was the more effective of the 2 preparations in the treatment of delirium tremens.

Webster(12) used ACE in the treatment of 9 cases with liver disease who were not responding, and reported improvement when ACE was added to the treatment program. He also noted improvement in the ability to abstain in those patients whose liver disease was secondary to chronic alcoholism. All 9 of Webster's patients had an "increased psychic stimulation as manifest by alertness and a feeling of well-being."

The frequent difficulty in management of patients with active delirium tremens in a general hospital led to the use of ACE. A second factor considered was the possible effectiveness in decreasing morbidity produced by the addition of ACE in the medical treatment. Patients with incipient delirium tremens who were agitated, apprehensive, and insomnious, but not hallucinated or disoriented, as well as those with active delirium, were given ACE to avoid the excessive doses of sedatives frequently required to obtain relief. One of the patients with severe cirrhosis showed a prolonged and disturbing period of confusion and coma after receiving a (short-acting) barbiturate during a surgical procedure. He was given ACE for his restlessness and agitation.

ACE was given in 5 cases of active delirium tremens in which the patients were having auditory and visual hallucinations, and were sufficiently agitated and restless to cause them to be a severe problem in a general hospital. Three patients with incipi-

ent delirium, who were tremulous, apprehensive, tense and nauseated, were also treated. In an effort to decrease the element of suggestion in the results, the patients selected were not advised of the nature of the medication they were receiving. The dosage was 30 cc., given in 3 equal injections intramuscularly during the first 24 hours, and 20 cc., given in 2 doses during the second 24 hours. The dosage given was the same whether the patient had incipient or active delirium. In addition to the ACE, the patients received 4,000 cc. of 5% glucose in normal saline during the first 48 hours, to which ascorbic acid and the B complex vitamins had been added. Chloral hydrate (2 g. initially and 1 gram every 4 hours as necessary) or paraldehyde (16 cc. orally initially and 10 cc. every 4 hours as necessary) was used for sedation. The surgical patient with cirrhosis received 10 cc. of ACE i. v. every 4 hours as necessary for his postoperative confusion and restlessness.

RESULTS

Seven of the 8 cases required sedation in addition to the ACE during the first 48 hours; no appreciable decrease in morbidity was noted in these patients as compared to patients treated with the same routine without the ACE. A follow-up of 3 to 9 months showed that 5 of the patients had been on at least one alcoholic bout since the time of their treatment with ACE, and no significant change in their drinking pattern has been observed. Of the 2 patients abstaining, one was cirrhotic and the other is on antabuse.

The patient who was given the ACE postoperatively was relieved of his restlessness, and was much more easily managed with this medication; too, the giving of more sedative, which was poorly tolerated, was avoided.

The following case is included because of the similarity of the symptoms and the treatment, except for the factor of the ACE being added at the time of the second hospitalization.

A 49-year-old white male was seen following a bout of 8 days' duration and was found to have incipient delirium tremens, characterized by restlessness, apprehension, food intolerance, and depression. He had heard no distinct "voices" but impersonal sounds were thought to have some "meaning" to him and were interpreted as threats. He appeared to be in a state of panic. He was hospitalized and was treated with glucose in normal saline, vitamins, and sedation. He was much improved in 12 hours and was discharged 48 hours after admission. Two weeks after his first hospitalization he resumed his drinking and was seen again when he became ill. His appearance and symptoms were identical with those seen at the time of his previous admission.

He received 30 cc. of ACE intramuscularly during the first 24 hours, and 20 cc. during the second 24 hours. The time required for him to recover, and the sedative required to control his agitation, were the same when he did not receive ACE as when it was administered. He was advised to return for further injections of ACE but failed to do so. He resumed his drinking 10 days later. Presently he has been abstinent for 5 months; however, he has been on antabuse during this period of sobriety.

DISCUSSION

ACE has been used in 8 cases of delirium tremens, 5 in active delirium and 3 in a state of incipient delirium. The addition of ACE to the treatment program did not obviate the need for sedation in any of these patients; however, this series was too small to determine whether significantly less sedation would be required routinely if ACE were added to the treatment program. No appreciable decrease in morbidity was noted in these patients.

Ten cubic centimeters of ACE every 4 hours was an aid in controlling the restlessness and delirium in a patient with alcoholic cirrhosis during his period of postoperative delirium. It would appear that ACE in sufficient dosage (10 cc. every 4 hours) is an aid in the management of the alcoholic with severe liver disease who has an increased tolerance for sedatives but insufficient liver function to metabolize whatever sedatives may be administered.

The cost of ACE is such as to make it prohibitive for routine use. None of these patients received ACE except during the acute illness; however, the possibility of a compensatory atrophy from the prolonged use of ACE has been pointed out by several authors (5, 6, 9).

CONCLUSION

1. In 7 of the 8 patients ACE in the dosage given did not obviate the need for sedation.
2. In this series, ACE failed to decrease significantly the morbidity.

3. ACE in large doses should be considered as a means of sedation in an alcoholic with cirrhosis in whom barbiturates are poorly tolerated.

4. The administration of ACE to chronic alcoholics failed to alter their drinking pattern after they recovered from the delirium.

PART II

The Use of Pantothenic Acid in the Treatment of Chronic Alcoholism [3]

Recently chronic alcoholism has been described as a deficiency disease occurring in patients who inherit an unusual requirement for particular nutrients. In this same period, it has been described as a metabolic disorder and compared to Addison's disease, or a state of hypoadrenocorticism. Beneficial results are reported in the treatment of chronic alcoholism by correcting these postulated etiological factors independently. The reported occurrence of adrenal necrosis in animals on a diet deficient in pantothenic acid, and the frequently evident inadequate dietary intake of the chronic alcoholic lead to the empirical trial of pantothenic acid in the treatment of chronic alcoholics.

METHOD

Pantothenic acid was given to 9 patients, all of whom had failed on other methods of treatment. The preparation used was Ca pantothenate orally. Since the daily requirement in man has not been established, the arbitrarily chosen dosage was 10 mgm. 3 times a day at the start of the treatment. If the patient was not successful in abstaining, this dosage was increased to 40 mgm. 3 times a day, or a total daily intake of 140 mgm.

In 5 patients the drug was combined with other fractions of the B Complex on the basis that its effectiveness might be increased. The only objection to the treatment program arose from the number of "pills" the patient was required to consume.

The average age of the 9 patients tested was 39.1 years; the oldest patient was 53 and the youngest was 23. The group treated had been sufficiently alcoholic to be unable to work regularly for an average of 6 years. Eight of the 9 patients had had delirium tremens on one or more occasions. These 9 patients had married a total of 13 times; and only 2 were living with the spouse at the time they were treated. They were all of average or better intelligence; 3 of the patients had spent time in college, none had graduated.

None of the patients was psychotic; 4 were extremely tense and gave as their reason for drinking an attempt to overcome their "nervousness." These 4 patients showed a tremor of the extremities; they were quite sensitive over this objective evidence of their tension and stated that the tremor had existed prior to the time they started to drink, and was temporarily relieved when they took alcohol.

Only one of the patients described any subjective effects from taking the pantothenic acid, and this patient, instead of taking the 140 mgm. in 3 doses, took the entire dose at one. This patient felt herself to be less tense after consuming fourteen 10-mgm. pills at one time.

RESULTS

At the end of the first week 7 of the 9 patients reported improvement from taking the drug; by the third week 4 remained optimistic over the preparation's effectiveness. After 2 months only one patient continued to take the drug. This patient was convinced that it decreased her chronic tension state and tremor; but there was no objective evidence that it altered her drinking pattern. The administration of other fractions of the B Complex in combination with the pantothenic acid revealed no increase in its effectiveness.

DISCUSSION

Pantothenic acid as Ca pantothenate has been given empirically to 9 chronic alcoholics without any evidence of its being effective in controlling their tendency to drink. It was used in a daily dosage beginning with 30 mgm. and increased to 140 mgm. per day. This preparation was given alone and in combination with other members of the B Complex.

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[3] Material for this study was furnished by Eli Lilly Company.

BIBLIOGRAPHY

1. Daft, F. S., and Sebrell, W. H. Hemorrhagic adrenal necrosis in rats on deficient diets. Publ. Health Rep., Wash., **54**: 2247, 1939.

2. Daft, F. S., et al. Effect of synthetic pantothenic acid on adrenal hemorrhage, atrophy and necrosis in rats. Publ. Health Rep., Wash., **55**: 1333, 1940.

3. Mills R. C., et al. Curative effect of pantothenic acid on adrenal necrosis. Proc. Soc. Exp. Biol., **45**: 482, 1940.

4. Nelson, A. A. Hemorrhagic cortical necrosis of adrenals in rats on deficient diets. Publ. Health Rep., Wash., **54**: 2247, 1939.

5. Sayers, G., and Sayers, M. D. Regulation of pituitary adrenocorticotrophic activity during the response of the patient to acute stress. Endocrinol, **40**: 265, 1947.

6. Selye, H. Compensatory atrophy of the adrenals. J. A. M. A., **115**: 2246, 1940.

7. Smith, J. J. A medical approach to problem drinking. Quart. J. Stud. Alcohol, **10**: 251, 1949.

8. Smith, J. J. The role of the adrenal gland in alcoholism. Proc. First Clin. ACTH Conf., p. 566. J.R. Mote, Ed. Blakiston, Phila., 1950.

9. Thorn, G. W. Diagnosis and Treatment of Adrenal Insufficiency, p. 99. Thomas, Springfield, 1949.

10. Thorn. G. W., et al. Studies on the relationship of pituitary-adrenal function to rheumatic disease. New Eng. J. Med., **241**: 529, 1949.

11. Tintera, J. W., and Lovell, H. W. Endocrine treatment of alcoholism. Geriat., **4**: 274, 1949.

12. Webster, J. J. Adrenal cortex in liver disease. Ann. Int. Med., **33**: 854, 1950.

13. Williams, R. S. Nutrition and Alcoholism. Norman, Okla.: University of Oklahoma Press, 1951.

SOME DIFFICULTIES IN GROUP PSYCHOTHERAPY WITH PSYCHOTICS[1]

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In this paper we shall describe some common difficulties that we have encountered in group psychotherapy with psychotics at the Boston State Hospital. Our clinical material is representative of the total staff experience over the past 6 years.

Group psychotherapy is conducted with groups of 10 to 15 patients meeting 2 to 3 times weekly for periods of approximately 1 hour. Our technique we have described in previous papers as participation in casual conversation with appropriate comments at opportune times.

One of the most common difficulties that we have encountered is making a clear working agreement with patients. One therapist, for example, earlier in his experience when organizing his group before the first meeting, individually invited patients to attend with a statement to the effect that group meetings were about to be held and that problems and feelings would be discussed. It seems fairly plain that this statement would not adequately cover certain questions that the patient might reasonably be expected to have in mind: "What can I hope to gain from these meetings? How is it going to be done? What am I supposed to do? What is the doctor going to do?"

We feel that an effective working agreement would include 4 elements: (1) the purpose of the group, (2) the method through which this purpose is to be realized, (3) the role of the members, (4) the role of the therapist.

Our current concept of group psychotherapy is that the group offers a patient opportunity to test reality in a protected setting and apply what he learns to his current real-life situation as he sees fit. In other words the patient can practice sizing up the other person's point of view, in the process of which he might get a new angle that will be of help to him in making sense out of his current difficulties.

On this basis the ultimate purpose of the group would be to provide a setting in which patients can gain experience in appraising situations more objectively and, if they so choose, to apply what skills they learn in order to function more effectively as persons in the community. Final or clear-cut answers are not necessarily expected, but rather the experience of trying to answer questions for oneself.

The method through which the members may hope to gain this experience is discussion, exchanging opinions, ideas, and personal experiences to see what they can learn from others in the group. It is assumed that skill in evaluating difficult life situations is gained through practice and that this practice is the method of the group. The role of the members would be to contribute opinions, questions, ideas, and in general participate in the discussion.

The role of the therapist would be to help the group overcome stalemates arising from intense differences of opinion. It may also be ventured that the therapist serves as a figure for identification, thus guiding the patients in their efforts to test reality, but we would rather not elaborate on this function of the therapist in this paper.

An effective working agreement as stated to a patient would then run roughly as follows: that the therapist will be meeting with a group of patients for purposes of discussion of everyday problems and difficulties, that in this group the patient may get some ideas that will help him in his efforts to understand his current difficulties, that the therapist would like him to contribute to the best of his ability and, lastly, that the therapist would like to have the privilege of contributing only when he feels it will be useful to the group.

Often it is more practical to make such an agreement by approaching patients individually before the first meeting with a brief repetition at the beginning of the first meeting. In addition to the goal, method, role of the patients, and role of the therapist, a working

[1] Read at the 108th annual meeting of The American Psychiatric Association, Atlantic City, N. J., May 12-16, 1952.

agreement should include the schedule and place of meetings, details regarding attendance, etc.

Through the working agreement we feel the therapist commits himself to a certain measure of responsibility and also indicates that the members have specific responsibilities. The working agreement also serves as a reference point for the timing and phrasing of comments by the therapist. It might be mentioned that this differs from chastizing patients when they deviate from the original agreement. Rather the therapist is helped in his attempts to be aware of what is going on in the group by watching for deviations and attempting to understand why they occur when they do.

In asking ourselves why various elements of the working agreement are frequently not clearly stated or else entirely overlooked, it seems to us that we sometimes did not ourselves clearly understand what the purpose, method, and roles were, largely from our lack of experience in psychotherapy and in understanding the therapeutic process. In addition we have noted a certain reluctance initially to commit ourselves to a well-defined role in the group because of reluctance to take upon ourselves the responsibility so implied.

It might be noted that group therapy offers the patient an opportunity to achieve a certain goal, that he has the privilege of taking advantage of this opportunity or declining it, and that success will largely depend on his own efforts.

This leads us to a second difficulty, namely, the difficulty in letting patients try to learn for themselves. We have frequently noticed a tendency in therapists to do things for the patient, thus depriving him of the satisfying experience of mastering difficult situations for himself. This difficulty manifests itself in an inability on the part of the therapist to focus on the interaction in the group. It seems to us that this difficulty is related to what other workers have called individual therapy in a group setting. The therapist in this situation tends to concentrate his efforts on a favorite patient or two, thus discouraging participation on the part of the other patients. This situation is particularly prone to develop in small groups or in chronic groups, in which there may be silent members.

One therapist, for example, with a group of male patients directed his therapeutic efforts toward one particular patient in the group. In the course of being sounded out by the therapist this patient disclosed many interesting details of his personal life. In relating these details the patient addressed himself almost exclusively to the therapist, only occasionally glancing at the other members who were at such times for the greater part silent. The other members did, however, make attempts to insert themselves in the conversation, sometimes successfully breaking up the dialogue between the therapist and the favored patient. It would not be long, however, until either the favored patient or the therapist re-established this dialogue.

In this example one patient is relating to the therapist rather than to the other members of the group. Thus through disclosure of intimate details he seeks reassurance from a bigger and stronger figure rather than risking the discomfort of subjecting his remarks to the critical scrutiny of the other members of the group. The therapist through this implied reassurance has encouraged the favored patient to avoid facing his difficulties as well as suppressing the interaction. Expression of opinion on the part of the other members would as a matter of course result in disagreement with the favored patient, thus tending to force him to face the lack of objectivity in his opinions about his personal difficulties. The therapist has thus deprived all the members of a potential learning experience.

It is interesting to note that the favored patient in this example showed increasing signs of regression when new members were introduced into the group. It seems to us that increasing regression is not infrequently the fate of the favored patient if the therapist does not alleviate the situation by attempting to promote greater interaction.

We see from this example that the therapist when focusing his efforts on a single patient prevents participation by other patients, deprives all the patients of a learning experience and the satisfaction of doing things for themselves, and fosters regression of the favored patient. It is worth noting that in depriving patients of experience in the group through inability to focus on the interaction, the therapist also deprives himself of the experience of facing whatever issues are involved.

It seems to us that such maneuvers by the therapist reflect a disproportionate emotional investment on his part concerning the issues brought into focus by the group or any given patient. It is thus implied that the therapist

in the previous example for reasons of his own was unable to be objective toward the disclosures of the favored patient. This was camouflaged by continuously encouraging the patient to further disclosures and preventing the development of a situation of critical appraisal. Critical appraisal of these disclosures by other patients would tend to bring to the therapist's attention his own lack of objectivity in the situation.

Failure to focus on the interaction then can in this sense be used defensively by the therapist. In such a situation the therapist not only deprives himself of new experiences, but also sets a poor example for the patients.

Inability to let patients learn for themselves is frequently associated with a belief that the patient is helpless in his current regressed state, a conception that overlooks the fact that the patient was not so long ago a functioning unit of some capacity and still is at least potentially able to function at his former level of adjustment. It is our observation that psychotic behavior is often the response to a situation in which the patient is unable to make simple yet vital decisions. The particular function of group therapy we feel is to keep the patient's appraisal of this impasse active in the hope that he may eventually work out a more realistic or less psychotic solution.

This does not necessarily mean that the patient must speak of nothing during the group sessions but his difficult real-life situation. Patients do spend considerable amounts of their time outside the group thinking over their difficulties. We see the function of the group as a stimulant for further constructive effort on the part of the patient.

The special conflicts that have resulted in the impasse will of course be reflected in the patient's preoccupations and productions in the group setting. At various levels they may concern problems of hostility, dependency, old oedipal struggles or sibling rivalry problems. These conflicts themselves we feel need not be directly clarified or even verbalized in the group setting.

For example a 50-year-old male patient when admitted to the hospital showed delusions of persecution and jealousy, auditory hallucinations, and bizarre sexual preoccupations. A history of the present illness revealed that the patient's household included an older alcoholic brother with whom the patient was spending more and more time drinking. The patient's wife had for some time been urging that the brother leave the home. In spite of his wife's mounting dissatisfaction the patient could not allow this, feeling it would be an unpardonable breach of family loyalties. Inability of the patient to come to a decision and appropriate action eventually led to an intolerable situation in which he attempted to comfort himself by reverting to wishful thinking and rather unusual explanations of his predicament.

In group therapy this patient never verbalized his delusions or hallucinations. He hinted at his real-life situation in making references to what a bad influence his brother was on him. The greater part of his productions, however, concerned his differences of opinion with the hospital authorities—he was not sick; he was being unjustly held; psychiatrists didn't know what they were doing, and so forth. These verbalizations were vigorously questioned by the other group members and this exposure to difference of opinion was apparently helpful in stimulating the patient to think through his impasse and come to a decision, for when interviewed prior to release on short visit, he stated quite plainly that he had thought over the situation and decided that out of fairness to his wife he would have to ask his brother to leave the house. This he actually was able to do on his first visit home.

We see then that a patient can apparently be helped out of a regressed state in group therapy without going into details of his personal conflicts or even the impasse leading to his regression. Experience in exchange of opinions perhaps stimulates a patient to think over his real-life situation, enables him to come to a more realistic appraisal, make necessary decisions, and pursue a more effective course of action.

On the other hand, failure to promote interaction in the group, as has already been indicated, deprives both the therapist and the patients of potentially constructive experiences. Situations are not permitted to develop fully in group setting through the active interference of the therapist who is at such times possibly satisfying his own personal needs in the guise of therapy.

Restrictive or defensive attitudes in therapists are revealed in many other ways. Some therapists lay down strict rules. Some choose members on the basis of attractive character traits. Others promote friendly responses from members while some promote hostile responses.

The therapist, we feel, can in general restrain himself from interfering except when forces arise that tend to disintegrate the group and prevent it from working toward

its goal. Forces tending to disintegrate the group are in general those that close off issues from further discussion. They manifest themselves in many ways and from a practical point of view can be understood as reflecting negative feelings for the therapist. They can be resolved usually by helping the patients verbalize the issue involved.

For example, one patient disrupted group discussion by angrily insisting that her therapist had raped her. This statement was at first largely ignored by the group, but was later met with protests from the majority of members with one member, however, requesting to hear more about it.

The therapist then commented to the group that the insistent member must have a good reason for making such a statement. His impression was that this member was verbalizing an issue of significance to all the members, namely anxiety over closeness to each other and to the therapist, manifesting itself in the one patient as a hostile accusation of the therapist, in the majority of the other patients as a protest, and in one patient as a frank curiosity to hear more.

The therapist then encouraged all the members to test the reality of the hostile patient's accusations so that they might have the experience of mastering the anxiety in the situation. In the subsequent questioning of the hostile member and exchange of opinion that occupied the next 3 or 4 sessions, the group finally arrived at the impression that the accusation of the hostile member reflected a wish to be raped by the doctor.

Had the therapist indicated in the first place that the accusation was ridiculous or attempted to squelch this patient in some other way he would have closed off this issue from further discussion among the members. The therapist's suggestion that the patient must have had a good reason for her accusation tended to keep the issue alive and is a representative example of what we call the "appropriate comment."

The main function of the therapist then as we see it is to help the patients overcome resistances, particularly when they are unable to do this among themselves. There are, however, no hard and fast rules; in fact, it seems to us more important that the therapist have some measure of flexibility, passing an opinion or idea now and again, stimulating the patients to face a given issue, encouraging reality testing and giving the patients a hand when intense differences of opinion arise.

These are by no means all the difficulties that we have encountered in our experience in group therapy. We have described a few of the more common difficulties and tried to explain their significance in terms of therapeutic rationale as we view it in our current stage of development.

Summary

1. The difficulty in making a clear working agreement is described.

2. It is suggested that this difficulty is related to the therapist's lack of experience and reluctance to take responsibility.

3. An adequate working agreement is outlined.

4. The difficulty in focusing on the interaction and the associated belief that the patient is helpless in his current regressed state are described.

5. It is suggested that these deprive both the therapist and the patients of constructive experiences.

6. It is further suggested that they may be defensive maneuvers on the part of the therapist.

7. Some other manifestations of defensive behavior in the therapist are mentioned.

8. The specific role of the therapist in overcoming resistances is outlined.

DREAM MORPHOLOGY: ITS DIAGNOSTIC AND PROGNOSTIC SIGNIFICANCE [1]

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In the course of my experience with dream analysis and dream interpretation it became clear to me that the structure or pattern of the dream—that which I choose to call dreamaturgy or dream morphology—has diagnostic and prognostic significance, independent of and supplementary to both the manifest and the latent dream content. By dream pattern I intend specifically the structure of the dream, the scheme of the story told, and the *manner* in which it is told; its background, its actors, their doings and sayings, the dream's continuity or discontinuity, its cohesiveness or lack of congruity—all of this, I repeat in emphasis, apart from, and independent of, the symbol significance of the dream content. The dream thus viewed is perceived as a *Gestalt*. It proffers, among other things, an indication of the way in which the dreamer *fashions* his dreams, for each patient follows his own pattern of dreaming. His dreamaturgy, like his handwriting, is unmistakably and consistently his own. Yet within each individual's pattern there is scope for many variations, and the changes perceived reflect the patient's progressions and regressions during therapy. By the token of the witnessed changes in the dream pattern it is possible to gauge what progress the patient is making and to deduce certain prognostic indices.

In attempting to establish the basic dream patterns, I arrived at 4 morphological categories. These are as follows: First: the dream that has the pattern of a consistent story. Second: the dream that has the pattern of a *montage*. This order of dream is composed of disjointed, episodic elements, which, however, are projected upon a common and consistent background. This category also includes the "multiple dream," that is the dream that comprises several dreams dreamt serially in one night. The third category embraces the dream that meanders. This type of dream changes its vernacular, shifts its terrain, and is distinguished by its disjointedness and inconsistency. The fourth category embraces what may be best described as the amorphous dream. In this order of dream we perceive only vague and poorly delineated characters who execute few definitive actions, and who in the main register only diffuse emotional overtones and nuances.

The following are representative examples of the 4 dream categories. I give the dreams as they were reported. Here is a dream of the first category.

A few girl friends were spending the night at my house. My father was in the hospital and my mother was away for the night also (don't know where). Had an appointment with you and it was arranged that you come to the house. There were two other friends and myself and we got into bed. Myself and Joan in one bed, and Mary and someone else in the other twin bed. You arrived and we started talking right in the room. After a few moments I got up and said to you that I thought it would be best if we went into another room. It was slightly embarrassing. You agreed. After our session you were getting ready to leave, and I suggested you spend the night since my folks were not home. Their room was available. You accepted and lo and behold mother came home later that night unexpectedly. Some surprise and confusion existed for a short while and I think you shifted to the couch in the living room.

The story told in this dream is consistent and well formulated. Contrast this dream with one of the fourth category, that which I have labeled amorphous.

Something about H: He said he had two things which hurt him. It and something else. I said why don't you put penicillin powder on it, it sounds like a boil. We went on a long trip through Italy. Anita also went in another car. Ethel or someone like her brought dresses—many, a certain type of them, she said, one couldn't wear. A. and I went to P. to tell him we wouldn't come for Thanksgiving. E. the maid then came and said if we went downstairs there was a big party going. We went, masses of people, sat on different sides of the auditorium. Theatricals some famous men Sorpo or Soyol. A. was somewhere also. A. and I left after a while.

[1] Read at the 108th annual meeting of The American Psychiatric Association, Atlantic City, N. J., May 12-16, 1952.

This dream, in contrast to the first, is formless. It has no obvious "plot" and "tells no tale." It is in fact basically amorphous.

An example of the second category, that of the montage, is the following dream:

Something to do with the M's. A. is working there Saturday only and I visit him there and help out too. Not sure. We are planning to get married. Last day for working there and I do something wrong or something happens. Anyway I am to be beheaded. I have the rest of the morning until 2:00 o'clock while Mrs. M. goes somewhere. At first don't really take it seriously. Gradually realize that I am really going to be beheaded. When Mrs. M. comes back she is a little sorry but it is too late to change things. Start trying to think of ways to get out of it. The execution is going to take place on a special boat on the river. Somehow gets to be a whole group of girls which is going to be beheaded and Mrs. M. fades from the picture. Something about girls simply not being able to handle something on board ship correctly and therefore having to die. Nobody is being very wholehearted about executions but has to go ahead. Postponed for a few hours because Lourdes did not come in time. We are taking showers and getting ready for the executions. Two men are watching me and admiring my body. Across the hall in another shower stall is a man without genitals but otherwise masculine figure. Then I am consulting with A. as to what would happen if I would not go. See the ship coming in. Everybody is there as we go aboard ship. Everybody is dressed up in elegant gowns and the whole thing begins to have the coloring of the guillotine days. I am still terribly ambivalent whether to try an escape or not. There is some concept that we will revive but be rather lifeless or somehow changed. Finally I decide to escape but feel somewhat ashamed about it and also afraid. Even if I get away with it—will live with the burden of fear. In the meantime the first girl is being made to hold her neck over pot of boiling water to "steam it up" in preparation for the knife, and I begin to realize full impact of what is happening. Some fellow outside the door stands guard but he is cooperating with my running away. Calls boy friend who is out hunting and tells him to go back to the ship with the bloody knife to cover up my running away.

This pattern is, I feel, well named a montage. Distinctive and seemingly disjointed parts of the dream are superimposed upon a uniform background and are thus linked together. One can discern an intended pattern, though its discernment calls for close scrutiny. The principle motif here is a *beheading* and the locus is a "special boat on the river." All the rest is ancillary to the tale told.

Less well organized, but still not without pattern is the dream of the third category: the meandering dream that changes its vernacular, shifts its terrain, and is indeed distinguished by its disjointedness and inconsistency. The following is an example of this order of dream:

Somehow I was a young fellow in school but something which I do not recall was wrong with this and for the rest of the dream I was a girl. I came to visit me in the college room or my office. The girl I was talking to had on a red dress and was sitting on the window. She began hanging out of the window more and more and I begged her to stop because I was getting worried that she would fall out of the window. She laughed and said she would not get hurt and showed this by suddenly swinging her whole body out of the window, hanging on only by her hand. Then suddenly she let go and I was terrified and sure she had fallen but she came up again a moment later, laughing. I was astonished and asked her how she had done it. She said that when she was a child she was sick and had to exercise her muscles so that now she has very strong muscles.

Then I went to X., a small town some distance from the college. I don't remember what I did there but was waiting for the bus back, standing in a doorway, talking to some fellows. At least one of them was Negro. Then someone came down from upstairs and made some comment that frightened me a little. Another fellow, who had joined us later, went outside and I asked him to stay with me until the bus came. He seemed pleased that I asked him, put his arm around me and smiled. I had been afraid to ask him because I did not want him to think I was prejudiced against Negroes.

Then somehow I went into the building. Lot of girls from the college there. There was a swimming pool in the center and stairs going up one side to a platform which overlooked the pool. Started to walk up the stairs. There were girls all along the stairway, and there was quite a commotion. Then I noticed that all along the stairway and in the pool was a big collection of slimy animals and entrails and fish. I made a lot of jokes along the way and got all the way to the top. It was then that I realized the water was also full of these things and that I could not expect to swim.

Girls starting to make coffee *upstairs* by adding water to a thick, syrupy mixture like condensed milk. I told *her* that the bus was due in 3 minutes and that in fact it had arrived. I ran down but it had left. However, I saw it turn into the terminal and I ran there and caught it just in time. I thought *two* of the girls had not made it, but when we arrived they got out too and I could not understand how they got there so fast. They had some adventure, asking someone to drive them or something and that is how they got there.

This dream as can be observed is loosely constructed. It begins in "the college room or office," then shifts to the town X. The dreamer then enters *a building,* and there

comes upon a *swimming pool*. Coffee is served—upstairs; the bus is due in 3 minutes. The dreamer first "misses the bus," then catches it at the terminal, and finally winds up by wondering how the other girls got there "so fast."

In the 4 dream categories given, we observe a progression from the most consistently patterned and well-integrated dream to the one that is in effect patternless. I submit that the quality of the pattern of the dream is in numerous ways meaningful and significant. Thus I am convinced that the well-integrated dream, the one that tells a clear tale, bears witness to the fact that the dreamer has an inner appreciation of the nature of his difficulties, albeit on the unconscious level. As a corollary of this it follows that the less well-organized the dream, the greater the difficulties the patient is experiencing in perceiving, in appreciating, and in formulating his psychological problems. Since *insight* is both a prerequisite to, and essential *in*, effective therapy, the pattern of the patient's dream can serve to instruct us on the depth and extent of insight that the patient possesses. By observing the changes perceivable in the dream pattern of a given patient's dream we can construe the extent, rapidity, and direction of his progress. By the same indices we can also observe the patient's resistances, their intensity, endurance, and alterations. In general it will be found that as the patient gains insight his dream pattern will move away from the amorphous, and toward the first category—that of the consistent story.

I am sure I need hardly underscore the fact that these generalizations, though valid, present far too simple a picture of the subject matter. They cannot and must not be applied to specific instances and to particular experiences without added elaboration. Thus dreams do not usually embrace the entire complex of the patient's difficulties. Preoccupation may therefore shift from one set of difficulties to another; indeed, as is common in experience, the resolution of one difficulty may serve to bring relief only to unmask or to uncover other, and at times even greater, difficulties. In the light of this it is to be expected that the dream pattern will change accordingly. New and emergent conflict elements will tend "to confound rather than to clarify the plot," to obfuscate rather than to render consistent the dream. But this too can be grist to the therapist's mill, for if a shift is observed from the consistent to the less consistent dream pattern, the therapist may be alerted to the upsurging of new materials. Here it may not be amiss once again to underscore just what is intended by consistency within the dream pattern. The reference is to the morphology, to the structure pattern, of the dream. No consistency in the sense of the reality logic prevailing in the real and awake world is intended or involved. In the meaning given, all that takes place in *Alice in Wonderland* is bound together in a consistent pattern. Were *Alice in Wonderland* a dream, as in a sense it was and is, it would be classified as of the first category.

I mentioned the uniqueness of each patient's dream pattern. This too is noteworthy, and can prove illuminating. Thus certain patients consistently dream (and/or report) compact dreams, worked out in the manner of a syllogistic exercise. Others are rather prolix. Even when the essential pattern is consistent, their dreams are expansively conceived and executed with a largess of circumstance and action. Such are in the main the dream patterns of patients who prefer the indirect and tangential approach, even as the compact dream is common to the "direct and logical" personalities, those with limited or restricted affect exchange.

In the main it will be found that the dream pattern is a function of the personality of the patient. Indeed it could hardly be otherwise. Since therapy not infrequently modifies personality pattern, it is to be expected that the dream pattern will undergo corresponding change; and it does!

In describing the 4 categories of dream patterns I emphasized what I call their gross morphology. It was not then desirable nor is it now possible, for want of time, to detail the finer morphologic elements perceivable within each category. The tale told by the dream may not only be more or less consistent, but it can also be told with special attention to the logicalness of incidents, with a marked awareness of moods, with fine details as to colors, odors, and tastes, and

with other marked and noteworthy characteristics, as noteworthy in their absence as in their presence. These finer morphologic dream factors also are a function of the personality pattern of the patient.

In preparation for this rather brief communication (brief in the sight of the magnitude of the subject) I naturally canvassed the literature to see what, if anything, of a similar nature had been observed and reported by others. I did not survey *all* the dream literature, and hence it is possible that I missed some pertinent material. But granting this possibility, I still found little touching on the subject of dream morphology, and nothing comparable to the thesis I here present. It is noteworthy, however, that A. E. Maeder, of Zurich, in 1913 termed the dream "an autosymbolic phenomenon" and described 2 *kinds* of dreams. In the first "the action is lively or direct, energetic." "This quality," Maeder wrote, "may be made use of in prognosis, be it in the sense of an intensely progressive achievement or of an active resistance." The second kind of dream Maeder described as marked by indifference, indecision, vagueness, awkwardness, doubt, stagnation, or fixation. These too, according to Maeder, have "a certain prognostic meaning for the contemporary phase." [2] Maeder described a third order of dream—one that is teleological and anticipatory in character. It is unfortunate that Maeder did not pursue this subject further, for dream morphology is for certain a most pregnant and promising study.

It was Freud who affirmed that the dream is the royal road to the unconscious and so indeed it is. Unfortunately, Freud himself and his followers, in particular, have perhaps unwittingly, there being so much to do and to study, created the impression that the unconscious is the Dantesque region of the personality, where the repressed and the primitive abide in stygian darkness. Here and there, among Freud's writings one catches a glimpse suggesting that after all, he "knew better." But to Freud, the dream was, in the main, an adventure whereby repressed impulsions, uprising from the unconscious, evaded, deceived, and otherwise eluded the censor, and emerged as wish fulfilments.

The dream mechanism is, however, capable of greater achievements, and the unconscious is vastly more than the region to which the unacceptable and the inexpressible are banished. The unconscious embraces a vast portion of the total mechanism of the personality—and it has an integrative and an adaptive competence that is often anticipatory to, and at times transcending, that of the conscious and rational faculty. In the unconscious lies the deeper wisdom of both the body and the person. It is from this most significant resource and power of the unconscious that dream morphology derives its validity and importance. For the dream is an intelligence of the unconscious and the grammar, syntax, and pattern of its communication, whether it babbles and falters, or speaks knowingly, is no less pertinent than the elements it seeks to utter and portray.

The dream is indeed an autosymbolic phenomenon. It is the most immediate and the most intimate of the person's psychological operations. In this purview the dream might be credited with greater revelatory significance than any of the now utilized projective techniques.

[2] The Dream Problem, p. 29. Nervous and Mental Disease Monograph Series No. 22.

THE TRAINING OF ATTENDANTS, PSYCHIATRIC AIDES AND PSYCHIATRIC TECHNICIANS[1]

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There are over 600,000 hospitalized mentally ill in the United States. Do these patients receive adequate nursing care?

Of the 300,000 registered nurses actively engaged in nursing, under 10,000, or approximately 3%, are employed in all categories of psychiatric facilities. Of these only 4,132 are working in public psychiatric hospitals, and of this small number only 1,222 are engaged as general duty or staff nurses. The other 2,910 are assigned to administrative, supervisory, teaching, etc., tasks. Thus, of the total number of registered nurses actively engaged in nursing in this country, only 1.4% are working in public psychiatric hospitals and only two-fifths of 1% are actually engaged in giving bedside care to the mentally ill.

It is well known that almost 50% of all hospital beds in the United States are occupied by neuropsychiatric patients. It is less well known, however, that only 3% of all actively engaged registered nurses in America have the task of attempting to provide nursing care for these patients occupying almost 50% of all hospital beds.

In the United States the average ratio of registered nurses to patients in all categories of psychiatric institutions is 1 to 65. In the state hospitals, however, the ratio of registered nurses to patients varies from 1 nurse to 1,054 patients to 1 nurse to 39 patients, with an average ratio of 1 nurse to 106 patients.

When we consider that, of a total of more than 600,000 hospitalized mentally ill, over 475,000 are in the state hospitals it is evident that skilled nursing provided for these patients is woefully inadequate. The small number of registered nurses doing psychiatric nursing are physically unable to provide even basic nursing care for the hospitalized mentally ill.

To supplement the 10,000 registered nurses engaged in psychiatric nursing there are over 80,000 persons, most of whom are classified as attendants and a few as psychiatric aides and psychiatric technicians, etc., to help give care to the more than 600,000 hospitalized mentally ill. The burden of the bedside care rests upon the shoulders of these 80,000 workers. Adequate training for this group is of paramount importance. What are the facts?

There were in 1950, according to the American Psychiatric Association nursing personnel survey, only 135 educational programs for workers classified as attendants in operation. These programs reported from the various types of psychiatric hospitals varied in length from *one week* to 9 months, with hours of instruction varying from 10 to 390. The small number of programs reported in relation to the total number of institutions makes it self-evident that the majority of attendants did not receive formal training or adequate preparation for their jobs.

The situation as it exists today constitutes a national disgrace. The responsibility for this deplorable state rests with (1) the administrators of psychiatric hospitals, (2) the medical profession, especially the psychiatrists, (3) the responsible members of the nursing profession, (4) governmental agencies responsible for legislative and executive functions, and finally the general public. To accuse ourselves of neglect is not enough. We should attempt to learn how we got into the present mess and then consider what steps are needed to correct the present deficiencies.

In 1860 Florence Nightingale founded her training school for nurses at St. Thomas Hospital. The movement to train persons to give better nursing care because of her pioneering spirit and the help of other courageous nurses constitutes a challenging and brilliant chapter in the history of medicine and nursing. From the start the schools of nursing were given an important part in the programs of general hospitals. Administrators of psychiatric hospitals desirous of improving nursing care for their patients did

[1] Read in the Section on Mental Hospitals at the 108th annual meeting of The American Psychiatric Association, Atlantic City, N. J., May 12-16, 1952.

not long delay in setting up training schools for attendants. The first such school in the United States was inaugurated by Dr. Edward Cowles, superintendent of the McLean Hospital in Somerville, Massachusetts, in 1882. The second training school was organized in connection with the Buffalo State Hospital in 1884, and the third at the Kankakee State Hospital in Illinois in 1886. This movement grew rapidly. In a paper read at the International Congress of Charities in Chicago in 1893, Dr. C. B. Burr, superintendent of the Pontiac Michigan Asylum, stated:

> No less than nineteen American institutions now possess systematically organized and thoroughly equipped training schools for attendants, and for them may be claimed a special and important place in psychiatry. Their creation has been the logical outcome of a desire for improvement in asylum service on lines similar to those developed through nurses' training schools in general hospitals, and the necessity for their existence in promoting modern methods in the care of the insane has been generally recognized. . . . ."

In this same paper presented in 1893 the following objectives in the training of attendants were discussed:

1. The stimulation of discriminating ability.
2. The development of perceptive and reflective faculties.
3. The recognition and understanding of the patient as an individual person.
4. The development of tolerance for the patient's idiosyncrasies.
5. The development of adaptability and resourcefulness.
6. The gaining of an understanding of the nature of mental illness, the causes, symptoms, and treatment.
7. The development of skills in the nursing arts.
8. The achievement of a sense of the worthwhileness of the work.

In 1896 the Illinois State Board of Charities, the predecessor to the present Department of Public Welfare, sent questionnaires to the superintendents of the American Asylums, of whom 64 responded. Of these, 24 stated that training programs for attendants had been inaugurated and several others responded that training programs were in the planning stage. Some of the superintendents reported 2-year training programs for attendants with compulsory attendance as a requirement for employment.

Many of the 2-year training programs for attendants subsequently developed into 3-year training programs for nurses. Many of the registered nurses who are today engaged in the practice of psychiatric nursing were graduated from the training schools of the public psychiatric institutions. The present-day trend in nursing education has forced the closing of most of the basic nurses' training schools in public psychiatric hospitals. Generally those few states that have not closed their schools of nursing in the state hospitals have the largest number of nurses working in their public psychiatric institutions. For example, New York State, which still maintains basic nurses' training schools in some of its state hospitals, has 1,165 registered nurses working in its state hospitals. This number constitutes 28% of all registered nurses in the United States working in public psychiatric facilities. Thus New York State with its training program has 28% of all registered nurses doing psychiatric work in public psychiatric hospitals, leaving only 72% for the remaining 47 states.

In Illinois, where the basic nurses' training schools were discontinued in the state hospitals in 1938, the number of registered nurses has declined to a low of 220 in all the institutions caring for over 45,000 hospitalized mentally ill patients.

At present the trend to discourage basic nurses' training schools in specialized hospitals is stronger than ever. The present-day emphasis is on academic training of nurses to produce administrators, teachers, supervisors, etc. There is also an increasingly widespread demand for nurses generally in fields other than psychiatric nursing. Based on these demands for nurses it is clear that it can hardly be expected that the small number of psychiatric nurses now giving bedside care, in addition to administrators, teachers, etc., can be materially increased in the foreseeable future. The need for nurses in administration, teaching, and supervising, vital as these services are, should not blind us to the need for nurses at the bedside.

Improved recruitment programs in the effort to obtain more registered nurses for the psychiatric field are needed. The providing of better salaries, improved working conditions, oportunities for advanced training, promotional opportunities, and job satisfaction should be immediate objectives if more nurses are to be attracted to the psychiatric

field. In addition, serious study should be given to the possibility of reestablishing nurses' training schools in psychiatric hospitals.

Even though these objectives were successful to a marked degree, the number of registered nurses needed to provide minimal nursing care for the patients in psychiatric hospitals is so great that the major part of nursing care needed in these institutions would still rest, as it does now, on the shoulders of the attendants, psychiatric aides, or psychiatric technicians, etc. Since the need is not being met by registered nurses alone, to improve the care of the hospitalized mentally ill, the development and advancement of programs for the training of "attendants" is of greatest importance.

In 1896 the secretary of the Illinois State Board of Charities stated that a national survey of attendant training programs was made. This study was started because it was the board's belief that nursing care of the patients was then the greatest need of hospitals for the insane in this and other states.

Now over 50 years later, very recently Dr. William Menninger stated that the training of attendants or psychiatric aides "is perhaps the most significant program in psychiatry today. It [this program] will put modern psychiatric knowledge and skill within the hands of people who will use it in direct contact with patients, thus substituting therapy for custody and inactivity."

During the past 9 months this Association and the National Association for Mental Health co-sponsored 2 international psychiatric-aide training workshops. These workshops were attended by administrators, psychiatrists, psychiatric nurses, psychiatric aides, psychologists, as well as representatives of other disciplines. The first of a series, they are proceeding to develop their important topic along the following lines:

1. The past history and an evaluation of the extent of the problem.
2. The qualifications, recruitment, and selection of aides.
3. Training objectives, course content, and teaching methods.
4. Duty assignments and responsibilities of trained psychiatric aides.
5. Status, salary scales, licensure, etc., of the psychiatric aide.

Today psychiatric hospital administrators are aware of the acute need for better training for the persons who provide most of the nursing care for their patients. Few are satisfied with the degree and character of training now given. In not a few areas determined efforts are being made to improve and expand "attendant" training programs. A few significant programs are here reviewed: others just as good or better doubtlessly exist.

Among the more recent noteworthy attendant, psychiatric aide, or psychiatric technician training programs is the psychiatric technician training program of New Jersey. The first class admitted began training on April 1, 1947; this is a one-year program, and the first class was graduated in April, 1948. To be eligible for admission to this school the applicant must be over 18 years of age, must possess sound physical and mental health, must have aptitude for working with patients, and must demonstrate social and emotional maturity. In addition, the applicant must be a graduate of a standard 4-year high school course or must have passed a comprehensive test demonstrating the attainment of an equivalent level of education. The curriculum provides 300 hours of classroom instruction and clinical teaching, as well as carefully supervised ward experience in both mental and physical care of the patient. Both theoretical and clinical instruction are emphasized so that the student receives a balanced educational experience. This course for psychiatric technicians is offered in 4 of the New Jersey institutions.

There is also the California state hospital program. Here a comprehensive training course for psychiatric technicians is offered that is similar to the one in New Jersey. In addition to the basic psychiatric technician course, California offers 3 advanced courses for psychiatric technicians of progressively advancing categories. The California technician group is divided into the psychiatric technician trainee, the psychiatric technician, psychiatric technician I, and psychiatric technician II.

An outstanding program exists in Saskatchewan, Canada. This program, begun in 1947, is a most ambitious one for the training of workers to provide nursing care for hospitalized psychiatric patients. The short-

age of registered nurses, so acute in the United States was, and is, even more acute in Saskatchewan. To supply the need for trained ward personnel a 3-year training program for "psychiatric nurses," as Dr. D. C. McKerracher and his group have named these workers, was inaugurated. For admission to one of the 3 Saskatchewan schools the applicant must have completed the eleventh grade, be 18 years of age or over, and must among other things have a suitable personality, be industrious, observant and interested in learning about the causes and meaning of human behavior. In addition to this, good health, strong physique, integrity, and a wholesome and stable personality are prerequisites. The course is divided into the junior, intermediate, and senior years, and consists of lectures and discussion classes as well as practical training on the wards. The curriculum provides 516 hours of classroom instruction in addition to the clinical training on the wards. The Saskatchewan "psychiatric nurse" is trained to be a member of the psychiatric treatment team. All the workers in the Saskatchewan mental hospitals have either completed the 3-year training program or are in the process of being trained. This is a remarkable achievement and presents a challenge to all of us who are interested in the improvement of patients' care through training of nursing service personnel.

We also need to mention the Menninger Foundation School for Psychiatric Aides, which began operating in 1949 as a 3-year experimental project under the joint auspices of the Rockefeller Foundation, the Menninger Foundation, and the Topeka State Hospital. This school offers to student psychiatric aides an intensive 12-month period of training in the scientific and humanitarian care of mental patients. Didactic instruction and closely supervised clinical experience are utilized in the training program. This experimental school will later this year complete the 3-year program that had been planned, but despite the remarkable achievements that characterize the Menninger School program, the closing date has been set for this fall. All who are interested in the need for adequate training of aides, in what can be achieved by proper training, and in the challenges that are presented to us in this program are respectfully encouraged to study the excellent reports of the Menninger Foundation School for Psychiatric Aides.

In Illinois in 1951 an 18-month program for the training of psychiatric technicians was inaugurated. This training course is open to high school graduates who possess physical and mental health and who show aptitude for working with the mentally ill. The course consists of 790 hours of didactic work in addition to supervised clinical training in wards of hospitals for the mentally ill and the defective.

In 1951 the State of Texas inaugurated its technical nurse training program as a joint undertaking of the Texas state hospital system and the junior colleges of Texas. In a recent report by Dr. George W. Jackson and his associates the following basic objective was stated:

> The technical nurse program which was inaugurated in six of the Texas state hospitals on September 8, 1951, was created and designed to improve the care and treatment given to mentally ill by raising the quantity and quality of nursing care available to each patient. To reach this basic objective, a program was designed that would:
>
> 1. Produce well educated and properly qualified nurse technicians who, through their training and background, would be qualified to assess and evaluate the nursing needs of patients and thereby be able to carry out, with a minimum of supervision, all nursing procedures necessary to the proper care and treatment of mental patients.
> 2. Offer the individual a chance to broaden his special and cultural fields, while advancing himself technically.
> 3. Act to raise the social and professional standing of mental hospital workers.
> 4. Guarantee each student a chance to develop a foundation for further collegiate study.
> 5. Allow the production of large numbers of well qualified and well trained technical nurses in half the time generally taken to train professional nursing personnel.

In addition to age requirements of 18 to 45 years, high school education or its equivalent, a stable personality, good physical health, and a history of good school or work achievements are required for admission to the Texas technical nurse training schools. The course provides 2 full years of intensive training in the field of technical nursing: 1,050 hours of didactic training and 3,558 hours of supervised clinical training are required in these courses, which, by the way, carry 2 full years of college credit.

The Texas experiment is most challenging

and its successful completion will be another advance in solving the most urgent of our problems, namely, the challenge of improving the nursing care and treatment of the hospitalized mentally ill of America.

There are other excellent training programs for "attendants" in federal hospital facilities, including the Veterans Administration, the United States Public Health Service, Saint Elizabeths Hospital, as well as in a number of states, including Massachusetts, New York, Missouri, and others.

In view of the concern today, resulting in programs such as these, it is interesting to note again that, over half a century ago, 2-year programs for basic attendant training were conceived and had been inaugurated by mental hospital administrators.

Leaders in the fields of nursing administration and education are likewise aware of the urgent need for improving and extending the training programs for "attendants" in psychiatric hospitals.

In her recently published book, " The Education of Nursing Technicians," Dr. Mildred Montag, assistant professor of nursing education, Teachers' College, Columbia University, convincingly presents the thesis that the present program of professional nursing education cannot hope to produce an adequate number of registered nurses to furnish necessary and urgently needed nursing care, and that to meet the needs for nursing care a new category of nurses, for whom she suggests the name of "nursing technicians," and a training program of 2 years' duration on a collegiate level be established. If this program is required in the general field of nursing, it is needed a hundred times over in the field of psychiatric nursing.

Successful and adequate attendant training programs of the past have been lost in the development of registered nurses' training programs. It is now evident that the small number of registered nurses available cannot fulfill the needs imposed by the vast numbers of hospitalized mentally ill patients.

In order to reach our goal of providing improved nursing care of the mentally ill, we must turn to and further develop the training programs for attendants, psychiatric aides, and psychiatric technicians, and produce an adequate number of trained personnel capable of giving efficient nursing care in keeping with the best of modern standards of psychiatric treatment.

SOME LESSONS FROM EFFORTS AT PSYCHOTHERAPY WITH PARENTS[1]

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By the term "collaborative therapy" I understand simultaneous psychotherapy with *both* the emotionally disturbed child *and* his parent or parents. Such therapeutic work is done most commonly, I think, in psychiatric clinics for children. This method is the outgrowth of many influences operating over many decades. One of the most consistent of these influences is the fact that more and more often it is the parent who consults the clinic and brings the child. The clinic staffs have learned many things from more than a quarter of a century of experience with such situations(1-10). One of the lessons they have learned is that the parents are not merely interested responsibly in the child's emotional health and welfare. They have learned that the parent is also asking, more or less frankly, for help for himself as well.

There are many aspects of collaborative therapy with the family that are of interest and that could be profitably discussed. There are, for example, the theoretical question of the etiology of the child's disorder and the often practical question of who is the patient. There is the question of the advantages and disadvantages of this way of work as against direct psychotherapy with the child alone. There are also rather controversial questions about which professional members of the clinic staff—psychiatrist, psychiatric social worker, or clinical psychologist—can, may, or should be encouraged to learn to work with which member of the family. There are the everpresent questions about the thoroughness of personality change versus mere symptomatic improvement that any psychotherapeutic method may hope to achieve—and in which member of the family. In other words, will the child's disorder be less likely to receive adequate attention if clinical attention is "diffused" through the entire family? And there are many other questions(11, 12).

I shall not discuss any of these questions very directly or very fully. I am not only less interested in these controversies at the moment, but also feel that time does not permit exploring them. I am also unprepared to present data that might further much the decision on any of these questions. Any such effort, then, might add more fuel to the heat of the arguments about them rather than bring much light to the solution of the real problems.

I think, of course, that there are some advantages to this way of working toward the relief of a child's disorder. Occasionally we have an experience that supports this idea. I might, for example, give a very brief summary of a clinical experience reported in greater detail elsewhere (by a former staff member who did the work(13)).

A girl of 16 was brought to the clinic from another city by her mother who demanded that they be seen without previous appointment. The mother insisted that her daughter needed hospital care because of 4 to 5 daily epileptoid spells, amnesia for certain events, and inability to attend school for the previous 3 years. All these and other symptoms followed an acute febrile illness for which she had been hospitalized for 2 months. The girl had a paresis of the left hand and arm, and shifting anesthesias. The illness, diagnosed as an encephalitis, occurred shortly after one of several separations of the parents who had been married after their daughter was 8 years of age. Antiepileptic medication failed to affect the spells. A large neurotic component in her postencephalitic condition was suspected and she was seen by a psychotherapist in her home city 4 times a week for 21 months. Mother took her daughter to the office of this therapist for each visit, but herself had few discussions with him. It is certain there was no psychotherapeutic work with mother. During this therapy, her daughter's symptoms continued, punctuated by episodes of pseudocyesis, astasia abasia, aphasic symptoms, and anesthesias. After stopping this work, and after trying a course of treatment at an orthopedic hospital, mother left her husband at home and came to the clinic in a city about 500 miles away.

Since no hospital bed was just then available, mother, after much protest, accepted an appointment several weeks later for herself and her daughter for weekly outpatient visits. A stormy course with both followed for the next 6 to 8 months, with continued

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spells, broken appointments, neurological consultations, additional laboratory studies, and changes in medication. There were several changes of therapists for each of them during the 22 months of our work with them because of the termination of periods of service of the therapist. Mother was very dissatisfied with her first, a young and very inexperienced, therapist, and she constantly sought contact with her daughter's therapist with various demands. Mother's second therapist, an older, more intuitive man, seemed more useful to her. Thereafter her daughter's seizures decreased in frequency and she, the daughter, began to go out socially and was soon engaged to a man twice her age. Father came to the city to break up this engagement. There was much tension between all three, but especially between the parents. During this visit, father had several interviews at the clinic and talked with much anxiety and tension about his uncertainties. The upshot was the breaking off of the engagement. Both mother and daughter had another change of therapists. This time the daughter became dissatisfied with her therapist, who was younger than her first. Although she missed appointments and otherwise was reluctant to work with him, she enrolled in school and her spells occurred less and less frequently. Again because of a change in service, a change of therapists for the daughter was necessary. Because of shortage of staff time, it was decided this time that the mother's therapist try working with both of them. He was more advanced in training than any of the previous therapists.

During the final 10 or 11 months of work of both with this same therapist, the daughter continued in general to improve. The spells continued to decrease until at the end they occurred once or twice a month and did not disturb either mother or daughter. Medication was much reduced. She did well in school, participated eagerly and with much satisfaction in dramatics, and eventually graduated from high school. She had dates with boys more nearly her own age.

The one exception to her generally upward course was a period of acute exacerbation of an old atopic dermatitis. (She had had severe eczema in early childhood.) The mother who, just prior to this, had been talking with difficulty about her early sexual experiences, became more anxiously demanding of the therapist for additional specific therapy for her daughter's skin, although there were numerous medicaments at home prescribed by excellent dermatological consultants. She talked of being unable to sleep and of itching herself when her daughter scratched. She had strong impulses to scratch her daughter's skin. The girl, on the other hand, made few complaints about her skin.

During this period, which was around the holidays, the father came again to visit them. A guest couple staying with them used the only bedroom of their small apartment during the first night of their visit. Father and mother on the sofa in the living room spent a sleepless night because of their daughter's scratching and moaning on a cot in the same room. On the following night, at the girl's insistence, all three used the same bed in the bedroom while the guests were asked to use the living room. The mother told the therapist with a good deal of tension that the parents had intercourse during this second night, and they then all slept undisturbed. After this, and after further discussion by the mother, especially of her demands of the therapist, the daughter's skin symptoms and lesions subsided.

Information about them was obtained in a letter from the daughter about 18 months after termination of therapy at the clinic and after their return to their home city. The parents were separated. The daughter had been married to a man a few years her senior, but had left him to return to live with mother. There was no mention of the other old symptoms.

But there are many other experiences in which even such results are much less obvious and much slower in coming. I do not want to suggest by citing this example that this or similar instances could not be, or are not being, met quite successfully by clinicians with a particularly experienced skill by working primarily with the child himself. The written and verbal reports of such clinicians indicate little or no work with the child's parents that is explicitly agreed upon with them as psychotherapy. Neither do I wish to suggest that the question of direct psychotherapy with the child alone *or* collaborative therapy of the family is unimportant. It *is* an important question. But whether—*in addition to direct psychotherapy of the child*—psychotherapy with parents is generally essential, or only important or of value in certain clinical problems, is one that I do not wish to try to answer here.

Whenever possible, our own practice is to engage both parents as well as the child in psychotherapeutic work with members of the clinic staff. (The phrase "to engage both parents" covers a host of problems that, important as they are methodologically and theoretically, time does not permit me to discuss.) [8] Usually each of the three is assigned a separate therapist. All three—especially in outpatient work—are commonly seen only once a week for 45-60 minute interviews. In this case the 3 therapists are encouraged to discuss their individual experiences informally with each other often—after each interview, if possible. That each therapist with his own patient respects the confidence of his colleague's patient goes without saying. A regularly scheduled conference of the therapists with their supervisors and the

[8] I have discussed this problem previously (14).

consulting psychiatrist permits review of movements and trends of father, mother, as well as child, in the total work. This review often reveals also the deeper problems of each of them carried from their individual past into their mutual present. It often also makes clear the transference projections and distortions of any one or of all three of the family upon their own or another's therapist. It thus gives the staff an opportunity to see the neurotic expectations and disappointments of each of them with each other.

For example, father's current or recent difficulties in attaining economic security or sufficiently satisfying status outside the family circle may be one important source of his tension within it. It is then seen as one factor in what happens within mother and child and between them. The mother's reaction to father's moods—both of which may be regressive—may be expressed in sexual unresponsiveness to his changed approaches and result in frustrated sensual longings of both of them. Their tensions, their ungratified impulses, and discontent with themselves and each other may be, and often are, reflected in their attitudes toward the child—usually in spite of their great efforts to the contrary. This clearly becomes a factor in the child's feelings about himself, about them, and in his behavior generally. In all this, often the mother—but sometimes the father as well—becomes neurotically entangled with the child; that is, as if in some unconscious and disguised hope of compensatory satisfaction from a regressive identification with him. For the sake of the child's actual and apparent best interests, the internal war of each of the parents with himself smoulders submerged or flares up sporadically between them—rarely with any full settlement of current issues important to all three.[4]

Now and then it becomes very clear how father's own early childhood experience with his parents and siblings that led to his current strivings, goals, conflicts, and his particular disappointments with himself is now matched by the similar difficulties of his wife. The unconscious regressive wishes of each—precipitated or intensified by recent thwartings—that the spouse fulfill the exaggerated ideal of ever-loving parent for the shaken self becomes evident. The defense against this wish—also not clearly conscious—the self-contempt about playing the role of helpless child with the other also becomes evident—often in the recriminations against the other's attitude toward their own actual child.

Their own actual child, identifying with both of them, is still seen oscillating between them. He may be a shifting pawn for the attainment of the unintegrated, repressed impulses of each of the parents. To this he may lend himself as a way of obtaining his own immediate direct end, or as a revengeful gain against the momentarily disappointing other parent. He may also struggle desperately for his own identity against being thus overwhelmed. Most commonly he does both at different times.

If enough becomes known—that is, if therapists are sufficiently skilled, and if therapy has continued long enough, each member of the family becomes an understandable person in terms of his individual endowments and his particular experiences. At the same time, their mutual difficulties seem then the obvious, and in retrospect, the inevitable, end results of 2 distinguishable series of events: (1) the consequence of what sort of person each of them has been, is, and is becoming; and (2) the consequence of the events, internal and external to the family, that have affected their mutual life together. In this sense I would speak of the neurosis of the child as the loudspeaker of the family trouble—often of several generations of trouble.

All this, with individual variations, has been documented by many case studies—both published and in the files of many clinics.[5] I know very well that so brief and

[4] My thought here is that all this results from the repression and the partial failure of the repression within each of them of the *sadomasochistic distortion* of basic needs or impulses.

[5] Such variations, I am more and more coming to think, are probably sufficient determinants quantitatively for the severity, qualitatively for the thematic form, and temporally for the chronicity of any specific child's disorder as well as his measure of integration. No special emphasis is here necessary on the following point: that those intensifications of the neurotic conflicts of one or both parents *that involve the child*, and occur and continue during the child's earlier and more vulnerable stages of maturation, have a proportionately greater influence. The factor of the genetic endowment of the child, it seems to me, can be eventually estimated only after such postnatal influences are fully considered.

generalized a sketch of what impressions a therapeutic team may gain from work with a given family is not a very satisfactory way of presenting a clinical method. Succinct abstracts of specific cases would make the points more vivid. On the other hand, this could be called anecdotal and selective of the instances that best fit the thesis. I do not wish to minimize either the complexity of the problem, the difficulties for the therapists, or the number of failures that occur with this method. I shall now discuss some of the lessons we are learning, and the difficulties we meet in our work with the parents.

One of these difficulties is in learning that to work therapeutically with the parents is *not equivalent to blaming them,* either for the child's conflicts and difficulties or for any of their other feelings or behavior. This may sound elementary, but much experience shows it to be a primary lesson that one learns and relearns almost with every parent. There are many reasons for this difficulty. The child is, after all, brought to the clinic as *the* patient. He is found to be disturbed, in conflict with himself. He is often clearly in need of an experience with adults that may be at once less stultifying to his self-assertiveness, less exploitative of his dependence, and more firm and more clearly defining of the privileges and the responsibilities appropriate to his age, degree of maturation, and potential capacities. In brief, the parent's therapist often sees very clearly what the needs of the child are. He may at moments feel torn between what seems to be good for the child, and what might be best for the parent. In addition, the parent is very often extremely guilty about his feelings and attitudes toward the child and at the same time oversolicitous toward him, and pessimistic or hopeless about him. The self-blaming and defensive parent often begs for or demands specific suggestions or advice from his therapist about what he should or should not do with and for the child, and it is often difficult for the parent's therapist not to be caught in a dilemma. The dilemma is whether to say or do something "for the child's sake," or whether after some experience of failure with this latter move to refuse factor of the genetic endowment of the child, it to give the parent even the simplest information about the examination of the child—which the parent has every right to know. Eventually one learns that behind such conflicting attitudes of one parent are equally conflicting discontents with the other parent and usually still deeper lie unresolved conflicts from his own childhood with the parent's own parent and his own siblings(15). These latter conflicts are often clearly about the same problems as those of the child in treatment. All these conflicts simultaneously and progressively in the successful case appear in relation to the therapist, who often serves as the shifting object of these feelings and attitudes—and are reduced or resolved. Naturally, this reduction or resolution of conflicts does not always happen without retrogressions in the work. These retrogressions are evidenced by exacerbations of symptoms in the child, by critical quarrels between the parents, and threats of divorce, by appearance or increase of neurotic symptoms in the parent, by various moves to discontinue therapeutic work—or by a combination of all of them.

Another difficulty—or perhaps another aspect of the same difficulty—is in learning that psychotherapy with a parent is not equivalent to an opportunity merely to instruct, advise, or educate parents who appear to be "ignorant of modern psychology" or to preach to those who appear to be "unworthy" of having children entrusted to them. Nor is it an opportunity to exhort them to be more loving, more patient, more tolerant, or more firm toward their children than they can be toward themselves. It is probable that there are parents who are merely uninformed about the most effective ways of caring for a child. Such parents, I suspect, obtain what information they need from pamphlets, books, newspaper articles, well-baby clinics, physicians, pediatricians, and other sources. But parents who finally arrive at a psychiatric clinic for children are usually, in our experience, already well read, well lectured at. When one or the other parent says anxiously and insistently, early or late in the work, "I don't know what to do" or "I wish you'd tell me what you think," it is frequently a statement of an impasse, a dilemma in their own feelings. We are learning every day that such expressions of

ignorance are often the verbal equivalents of a jam between two of their own opposing attitudes that are just then of about equal intensity. How at such moments to encourage the parent to give full and sequential *verbal* expression to the welter of intense feelings and the often enormous quantity of anxiety he experiences belongs to the usual techniques of psychotherapy. But the awareness of a therapist that a child's welfare seems to be at the vortex of such a maelstrom of parental emotions may contribute to his hesitation or uneasiness about behaving with the therapeutic precision he might otherwise manifest. During such moments the parent may reveal such deep hatefulness (as well as panic and flight from the awareness of it) for the child, for the other parent, for the therapist, and finally for himself (*i.e.*, for his own distorted sadomasochistic impulses) that again his therapist may falter in adequately therapeutic behavior. One mother at such a time said of her child bitterly, "He's an octopus around my neck." She was referring simultaneously to her child, to her husband, the therapist, but at bottom (as she understood eventually) to her own conflicts from her childhood. It is experiences of this sort that perhaps lead a therapist to question the parents' capacity to achieve any genuinely parental attitude toward their child. But it is also after such intense moments of catharsis and abreaction with some relief in the therapeutic session—at least, after numerous repetitions —that one sees some changes appear within the family. When each of the parents has lived through such periods, he begins to live more simply both within and outside the family with fewer obstacles within himself. After some struggles to maintain the previous equilibrium, the child, too, responds to these changes in the parents as well as a result of his own therapeutic work in the clinic. It is interesting to find, when such things happen, how the clinic staff finds such expressions as "dependent, immature, rejecting, or domineering mother" or "passive, indifferent father" or "untreatable parent" (in the epithetic sense, as Whitehorn(16) puts it) less and less applicable to the parents they work with.

There are many other difficulties in such therapeutic work with parents. We have had to learn—again repeatedly—that there is no need to insist that a parent talk "about himself" to his own therapist. There is often a regular progression of content in the long course of the therapy of the parent as well as eventually within a given interview. The parent may first complain about the child, then about the other parent. Sometimes in the milder cases the child begins to be less troublesome to the parent at this point. And finally the parent either complains about himself and his past or talks about the therapist's uselessness to him. With enough experience with many parents and with a specific parent one is often able to understand before the parent becomes fully aware of what he is saying. One begins to understand that the parent is reporting about some of his own still unconscious feelings when he talks of the child's behavior, the other parent's attitude, or his suspicion about the therapist's feelings toward him. This often proves to be true even though the report about the child and the other parent is also partially true. At such times what response from the therapist would be most useful to the parent, and at what moment, is a matter of psychotherapeutic technique and the therapist's best clinical judgment. If, however, the therapist makes some error in judgment or in the timing of his interpretive questions and responses, this is not always irretrievable. If therapy is not disrupted, as it sometimes is after such errors, the parent sooner or later may lead the therapist to the whole truth—particularly if the therapist is convinced that his patient *can* lead both of them to a more complete understanding.

Difficulties in concomitant psychotherapy of parents might perhaps be summarized in part as arising from the *over*identification of the parent's therapist with the child. The parent's own lack of self-confidence, discouragement, and often enormous sense of failure also contribute to his therapist's uncertainties about the outcome, about his own usefulness to the parent, or about the value of such work with the parent to the eventual welfare of the child. Such doubts of the therapists are—especially during their periods of learning the method—at times expressed in doubts as to the precision or the

effectiveness of his team-mates working with the family. Sometimes such conflicts between the team of therapists are not easily resolved either in individual supervisory sessions or in treatment review conferences. Often only as a result of a sufficiently long period of working together with many different families do they acquire sufficient trust and confidence in themselves and in each other to speak frankly of their own difficulties with each of their patients. Such intrastaff difficulties are one of the reasons for early disruption of therapy by the family and for partial or complete failure of the effort.

It is partly such difficulties within the staff that have suggested occasional variations in the more usual pattern of assignment of separate therapists for each member of the family. In a training clinic, staff members are often not only in the process of learning psychotherapeutic technique; they are also asked to learn to work harmoniously and sympathetically with one another. To learn to do both at once is a large order even for therapists more experienced. All this they try to do in a limited training period varying from ½ to 1 or 2 years. Because there is everywhere a great number of families seeking help from every existing clinic, there is also a shortage of total staff time in relation to this demand. All these reasons have led us to experiment with 2 or only 1 therapist for child, father, and mother. This has been tried in a relatively few instances so far and for a relatively short period. Although difficulties have not disappeared with this change, in a very few instances we have found it *is* possible to be of some help to all three. Each of them may experience in varying degree and varying form distrust of the therapist, envy, and suspicion that he prefers one or both of the other family members. Rivalry between them for the therapist with retaliatory fears and defenses against such feelings are at times prominent. But such feelings, and others not described, have in these few families not proved impassable barriers to some amelioration of tensions between them and to some reduction of the child's symptoms.

I have spoken chiefly of the therapeutic work with the parents. I have mentioned the work with the child largely in passing. This does not mean that the therapeutic work with him is either less important, needs to be less precise, or is necessarily any less difficult when the parents are also in therapy. On occasion the obverse is true. The child's symptoms may subside with suspicious rapidity; he may—especially with some adolescents—tend to show less interest in the work and refuse to come; or show little or no improvement for long periods of time. These problems in some instances are clearly related to errors in the direct work with the child. In others they are expressions of some variant of the difficulty in the work with one or both parents. I have spent less time in speaking of the effect of precise psychotherapeutic work with the child and of the result of some resolution of *his* internalized conflicts upon his resumption of emotional growth and upon the reduction of the tensions of his parents. I have done this partly because I have assumed that the problems of the work with parents would be of as much interest to you as in recent years they have been to me.

In summary, I have tried to say what we mean by collaborative (perhaps it should be called concomitant) psychotherapy of the family; I have cited one clinical instance in brief outline in which psychotherapy of the parent has seemed to have had an advantage over direct work with the child alone; I have mentioned some of the questions that clinical experience with this method has raised without trying to adduce evidence for or against these theoretical and practical questions; I have finally spoken of the complexity of the problems in families seen thus and the difficulties we experience and the lessons we are learning, primarily from the work with the parents: namely, that psychotherapy with parents is neither blaming, nor merely instructing, advising, informing them, nor yet preaching to them; and I have pointed to still other difficulties still more briefly.

BIBLIOGRAPHY

1. Lowrey, Lawson G. Evolution, status and trends. Am. J. Orthopsychiat. (Trends in Therapy), 9: 669, 1939.

2. Dawley, Almena. Interrelated movement of parent and child in therapy with children. Am. J. Orthopsychiat. (Trends in Therapy), 9: 748, 1939.

3. Johnson, Adelaide M., et al. School phobia. Am. J. Orthopsychiat., 11: 702, 1941.

4. Szurek, Stanislaus, et al. Collaborative psychiatric therapy of parent-child problems. Am. J. Orthopsychiat., **12**: 511, 1942.

5. Wickman, K. M., and Langford, William S. Parent in children's psychiatric clinic. Am. J. Orthopsychiat., **14**: 219, 1944.

6. ——— Clinical aspects of parent-child relationships. Ment. Hyg., **32**: 80, 1948.

7. Langford, William S., and Wickman, Katharine M. Orthopsychiatry in pediatrics. *In* Orthopsychiatry 1923-48: Retrospect and Prospect, pp. 287-299. New York, American Orthopsychiatric Association, 1948.

8. Johnson, Adelaide M. Sanctions for superego lacunae of adolescents. *In* Searchlights on Delinquency, p. 225. New York, International Universities Press, 1949.

9. Szurek, S. A. Some impressions from clinical experience with delinquents. *In* Searchlights on Delinquency, p. 115. New York, International Universities Press, 1949.

10. Langford, William S., and Olson, Elma. Clinical work with parents of child patients. Quart. J. Child Behavior, **3**: 240, 1951.

11. Levy, David M. Critical evaluation of the present state of child psychiatry. Am. J. Psychiat., **108**: 481, 1952.

12. Johnson, Adelaide. Some etiological aspects of repression, guilt and hostility. Psychoanal. Quart., **20**: 511, 1951.

13. Sheimo, S. L. Concomitant treatment of mother and child: A case of mother and adolescent daughter. Read at annual meeting of American Orthopsychiatric Association, Atlantic City, Feb. 26, 1952.

14. Szurek, S. A. The family and the staff in hospital psychiatric therapy of children. Am. J. Orthopsychiat., **21**: 597, 1951.

15. Hilgard, Josephine. Sibling rivalry and social heredity. Psychiat., **14**: 375, 1951.

16. Whitehorn, John C. Basic psychiatry in medical practice. J.A.M.A., **148**: 329, 1952.

CLINICAL NOTES

HYALURONIDASE IN THE TREATMENT OF LOCAL INFLAMMATORY EFFECTS FOLLOWING INTRAVENOUS INJECTION OF 50% GLUCOSE[1]

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Insulin coma therapy of psychotic patients necessitates repeated intravenous injections of 50% glucose solution to terminate the comas. Since the patients are often restless and make it difficult to immobilize their arms during the injection, accidental extravasation into perivenous tissues of small amounts of the hypertonic glucose occurs fairly frequently. Various types of local postinjection reactions have been noted in the past. Marked localized swelling and severe pain usually developed within an hour of the extravasation. This generally progressed to a diffuse swelling of the hand or forearm and developed all signs of inflammation including heat, redness, and severe pain and tenderness if the extremity were touched or moved. This condition usually persisted about a week. Frequently this was followed by progressive cellulitis, lymphangitis, and thrombophlebitis. The patients developed fever, and the course was prolonged for at least another week.

Several types of treatment were tried with little apparent effect on the progression of the condition. Ice packs were applied. Anticoagulants and antibiotics were used for the more serious later complications. Generally the reaction ran its course, resulting in the interruption of the insulin therapy during that period.

It was assumed that these undesirable effects were probably due to the continued presence of a high concentration of glucose in the subcutaneous tissues. The osmotic effect of the hypertonic glucose caused a rapid early influx of tissue fluid, which was kept localized by natural tissue barriers. The expanding fluid volume caused pressure on lymphatics and blood vessels, decreasing absorption and causing pain. The pressure and the sclerosing action of the hypertonic glucose, if allowed to persist, had a necrotizing action on the tissues resulting in the later complications. Ascending red streaks and readily palpated cordlike veins gave evidence of the inflammatory involvement of the lymphatic and venous structures.

To speed the diffusion and promote the dilution and absorption of the extravasated glucose seemed to be the most logical goal of therapeutic attempts. Hyaluronidase appeared to be the most suitable available agent for this purpose. It is an enzyme that dissolves the cement substance between cells of connective tissues. The hyaluronidase, derived from testes, bacteria, and venoms, produces its characteristic spreading response described by Duran-Reynals(2) over a decade ago. It depolymerizes a hyaluronic acid gel believed to be a component of the dermal barrier that restrains the diffusion of fluids injected into subcutaneous tissues(3). The spreading effect is determined by the concentration of available enzyme, but also by the pressure and the volume of the injection.

Hyaluronidase has had its widest use in increasing the speed of absorption of infusions and even plasma(1), injected into subcutaneous tissues by hypodermoclysis. The rate of absorption could be increased by 40% or more. Hyaluronidase has also been used as an adjunct in the injection of local anesthetics(4), insulin(5), heparin(6), and other substances where rapid diffusion was needed. It has been successfully used in aiding the resorption of hematomas(6). Reports indicate that the drug does not result in any toxic or allergic reactions even when used in patients with systemic infectious diseases(3).

PROCEDURE

In this study are included all cases that developed marked swellings and pain at the

[1] From the Neuropsychiatric Service of the Veterans Administration Hospital, Bronx, N. Y.

site of the intravenous injection of 50% glucose solution in the course of insulin coma therapy over a 3-month period. A total of 20 reactions with swellings, averaging about the size of a hen's egg, was found on the treatment ward. In all cases the swelling was either on the dorsum of the hand or on the volar surface of the forearm. These 20 reactions occurred in 9 patients, some having several such episodes in the course of their therapy. The 6 controls were cases chosen at random. Hyaluronidase was withheld from these, but they were treated in the usual way with ice packs. The other 14 cases received subcutaneous injections of hyaluronidase [2] into the area of swelling; 9 receiving 1 cc. and 5 receiving 0.5 cc. of a solution containing 150 TR units per cc. Of the 14 cases, 11 received the hyaluronidase within 2 hours, 2 within 6 hours, and 1 within 48 hours after the intravenous glucose injection. Five of the 6 cases used as controls occurred in patients who had more than one episode. In these cases, the same patient served both as a control case and as a treated case, on different occasions.

RESULTS

Controls—Of the 6 cases treated with ice packs only, *without* hyaluronidase, all developed diffuse inflammation. In 3 the pain, tenderness, redness, and diffuse swelling subsided after one week or more. The other 3 developed thrombophlebitis toward the end of the first week of the condition, with fever and malaise. Penicillin was used, but the symptoms persisted for at least another week. The thrombosed superficial vein was easily palpated, and persisted even after the acute inflammation subsided.

Treated— Of the 14 cases treated with hyaluronidase, all had complete disappearance of signs and symptoms within 2 days, and not even one developed any complications. The 11 cases that received hyaluronidase within 2 hours of the glucose injection had a marked decrease in the swelling within several hours of the hyaluronidase treatment, with complete disappearance of the swelling within 24 hours. Seven of these 11 were also completely relieved of pain and tenderness within 24 hours, but in the other 4 the tenderness did not disappear until 48 hours had elapsed. In the other 3 of the 14 cases, in which the treatment with hyaluronidase had been delayed 6 and 48 hours, the swelling, pain, and tenderness disappeared completely within 48 hours of the injection of the hyaluronidase.

There was no appreciable difference in results when the dose of hyaluronidase was increased from 0.5 to 1.0 cc.

There was a transient burning sensation while the hyaluronidase was being injected. There were no other undesirable side effects in the treated cases.

[2] Wydase was the preparation of hyaluronidase used.

CONCLUSIONS

Although the number of cases is admittedly small, the results seem to indicate that 0.5 cc. of hyaluronidase solution, containing 150 TR units per cc., when injected subcutaneously into any area of pain and swelling following intravenous injection of 50% glucose, is sufficient to reduce the usual 1- or 2-week course of the condition to 1 or 2 days.

This treatment also seems to prevent the development of such complications as progressive cellulitis, lymphangitis, and thrombophlebitis in such areas.

For best results, the hyaluronidase should be injected as soon as possible after the development of the swelling, but delayed treatment, for as much as 48 hours, still seems to have some benefit.

The authors wish to express their appreciation for the cooperation and assistance in this project received from H. Flowers, M. D., chief of the neuropsychiatric service of the Veterans Administration Hospital, Bronx, N. Y., and other staff members.

BIBLIOGRAPHY

1. Burket, L. C., and Gyorgy, P. Clinical observations on the use of hyaluronidase. Ann. N. Y. Acad. Sc. **52**: 1171, 1950.

2. Duran-Reynals, F. Tissue permeability and spreading factors in infections. Bact. Rev. **6**: 197, 1942.

3. Hechter, O. Mechanisms of spreading factor action. Ann. N. Y. Acad. Sc., **52**: 1028, 1950.

4. Looby, J. P. and Kirby, C. K. Use of hyaluronidase with local anesthetic agents in dentistry. J. A. Dent. A. **38**: 1, 1949.

5. Straccia, F. A., and Scheflen, A. A. Hyaluronidase as an adjunct in insulin coma therapy. Am. J. Psychiat., **108**: 702, 1952.

6. Tuchman, M. S. and Moolten, S. E. Use of hyaluronidase in preventing the pain of subcutaneous heparin injection. Am. J. Med. Sc., **219**: 147, 1950.

PRESIDENT'S PAGE

THE DISTRICT BRANCHES AND AFFILIATE SOCIETIES

The district branches and the affiliate societies have now become a major division of the American Psychiatric Association. In 1941 there were 5 affiliate societies; 11 years later there are 34. Three years ago there was one district branch; there are now 6.

The exceptional rapidity of the postwar growth of the Association and highly significant increase in the vigor of its activities have alike demanded that the internal organization should be powerfully strengthened.

The central part has been so strengthened —by the establishment of the Medical Director's Office and its related subdivisions and facilities, as well as by the most considerable expansion in the number and activity of the standing committees, the commissions, boards, and *ad hoc* committees.

At this moment, there is going forward the work of bringing to equal strength the area organization of the Association and, in particular, of setting the central and area divisions into close working relations. By this means, a reservoir of immense but hitherto latent power can be set into action.

During the last 3 years there has been an active exchange of ideas and views on the matter between the Council and the district branches and affiliate societies. In this President's Page it is proposed briefly to sketch the present status of the arrangements that are now taking form.

It is essential to stress the fact that affiliate societies and district branches, differing as they do in their structure, have for this very reason separate and most valuable contributions to make, not only to the effectiveness of the Association but also to the development of psychiatry in general.

The affiliate society, because of its multidisciplinary nature—containing, as it frequently does, neurologists and neurosurgeons and internists and pediatricians as members —is able to achieve a working relationship with those disciplines that is extremely valuable. (a) Through this relationship it can enlist the support of these disciplines in a manner most important to us. (b) Through these contacts it is possible to transmit information concerning psychiatric concepts to other members of these disciplines. (c) It is possible, through the attendance of these nonpsychiatric members in the affiliate societies, to contribute materially to their understanding of psychiatry and to their skill in the day-to-day utilization of psychiatric data.

The district branch has as its outstanding value the fact that, since it is composed entirely of American Psychiatric Association members, the business of the Association can become a matter of general discussion at its meetings. During these discussions, opinion is formed that in turn can be transmitted to Council and to the membership in general. With the rapid growth of our Association, nothing is more important than discussion of its affairs, the formation of opinion, and its transmittal for eventual action by Council and by the general membership.

Through their committee structures, the district branches and affiliate societies can provide areas of experience for men who have not yet progressed to Fellowship in the Association and who, therefore, are not eligible for membership on the standing committees of the American Psychiatric Association. The Association is continually on the alert, through its officers, for younger men recently elected to Fellowship who have had experience and have shown their capacities in committee work with affiliate societies and district branches, since there is a steady demand for such individuals to serve on the standing committees, the boards and commissions, of the Association.

It should also be recalled that a great deal of the organizational and developmental work of psychiatry can only be done locally. The standing committees of the Association can, and do, work out over the years proposals and programs based upon the data and opinions collected from across the continent. These proposals of the standing committees are then referred for further evalua-

tion, check, and revision to the Executive Committee, to Council, and then are presented to the membership for final authorization. But if the proposals are actually to go to work for us they have to be backed locally by a locally organized body. For instance, the committee on clinical psychology of the American Psychiatric Association is at present working out proposals relative to the certification of clinical psychologists and proposals relative to dealing with legislative bills put forward by certain bodies concerning the licensing of clinical psychologists. These proposals will not achieve their full effectiveness unless they are taken up and vigorously applied by the district branches and affiliated societies, each working in its own locality. The same applies to the proposals of many other standing committees, such as that of academic education, that of hospital standards and policies, and that of industrial psychiatry.

Hence, in recent years, there has developed an increasing desire to see the affiliate societies and district branches work in the closest possible relationship with the standing committees of the Association. Probably the principal way in which this can be achieved is through the district branches and affiliate societies setting up committees to act locally in association with such of the standing committees of the American Psychiatric Association as are engaged in work that is of special importance to a particular district branch or affiliate society. Of course there are far too many standing committees within the Association to permit of all district branches and affiliate societies setting up committees to collaborate with each one of them; and, indeed, the requirements of a given district branch or affiliate society might not, by any manner or means, call for such duplication. For instance, an affiliate society drawing most of its members from rural areas would be unlikely to be interested in the work of the committee on industrial psychiatry. But there must be few district branches or affiliate societies that do not find value in collaborating with committees having such universal significance as that on therapy, on psychiatric nursing, research, academic education, public education, clinical psychology, hospital standards and policies, and others.

In recent years, the American Psychiatric Association has taken several steps toward fostering the closest possible relationship between the district branches and affiliate societies and the main body of the Association. Some of these steps have already been incorporated in constitutional amendments—as, for instance, the proposals for an Assembly to be set up when 8 district branches have been established. (Since there are now 6, it is hoped that further applications will come forward during this year to permit the setting into action of the Assembly next May.) The function of this Assembly would be one of continual and outstanding importance: namely, the developing of opinion on matters of importance to the Association. It undoubtedly will serve, with passing years, as a most effective means whereby the views and the proposals and the criticisms of the district branches can find expression and ultimately be transmitted to Council for further consideration and eventual action.

In regard to the affiliate societies, it was proposed to Council—and this proposal was accepted—that the affiliate societies should be encouraged to set up a committee of affiliate societies, and that this committee should undertake to debate matters of concern to the affiliate societies and transmit this opinion, through its representatives, to Council.

An *ad hoc* committee under the chairmanship of Dr. C. N. Baganz has been set up to deal with the relations between the American Psychiatric Association and its district branches and affiliate societies. Meetings of the representatives of the district branches and affiliate societies with the officers of the Association, as well as with the chairmen of the standing committees, have been organized at the time of the annual meeting.

In review, there are few areas in the Association in which one can see more plainly and strikingly the promise of immensely expanded effectiveness than that which awaits the bringing of the district branches and the affiliate societies into full functioning relationship with the association. Further information concerning the setting up of district branches and affiliate societies may be obtained by writing to Dr. R. Finley Gayle, Jr., the Secretary of the Association.

D. Ewen Cameron, M. D.

COMMENT

NEW YORK STATE PROGRAM ON ALCOHOLISM

The expanding role of psychiatry that goes hand in hand with broadening recognition of its function can be measured by many yardsticks. Perhaps mos. significant is the growing concern of public agencies with social problems having strong emotional components. One of the most pressing in recent years has been the problem of chronic alcoholism. There is today considerable divergence of opinion as to the relative weights of psychic and somatic elements in this disease, but what emerges is a fairly clear concept of emotional motivation complicated by metabolic conditions and reactions.

Here obviously is a problem of both the body and the mind—a task for both psychiatry and internal medicine. In terms of governmental administration it involves both mental hygiene and public health. In New York State the required combination of effort presents no difficulties. The Mental Health Commission, created by the Legislature in 1949 and comprising the heads of 5 state departments, provides the necessary machinery. Operating within the Department of Mental Hygiene, the commission attempts to coordinate both state and local activity at the community level in the various fields that impinge on public mental health.

Since 1948 the state has conducted a research clinic for the study of alcoholism in the City of Buffalo. It is now part of the Chronic Disease Research Institute at the University of Buffalo School of Medicine. This year Governor Dewey recommended to the Legislature provision for the establishment of another clinic in New York City, the extension of state aid to qualified clinics for alcoholics in other communities, and a program of research. A bill appropriating $145,000 to carry out this recommendation was subsequently passed by the Legislature and the responsibility for the program was placed with the Mental Health Commission.

In dealing with alcoholism, as with other community mental hygiene problems, we are approaching something that is an integral part of family and neighborhood life. Our patients are not segregated in institutions where we can exercise almost complete control over environmental influences—only those who actually cross the borderline of psychotic behavior are admitted to state hospitals. Rehabilitation is a matter that requires the cooperative efforts of many individuals and groups who touch the daily life of the patient. Family, friends, neighbors, and business associates must be educated to the patient's needs and the true nature of his ailment. Cooperation of other agencies must be enlisted both in the general approach and in specific situations.

For many reasons, then, a program for the treatment and rehabilitation of chronic alcoholics must be multi-disciplined, integrating at all levels the resources of both public and private agencies. By the same token, prevention, which must be the ultimate goal of any such program, can be achieved only by concerted effort. The attitude of the general public must be modified to accept alcoholism as a disease, a medical rather than a moral problem, and a community responsibility. Research in causes and treatment may lead us to simple methods of prevention and cure, but in the light of our present knowledge the effective weapons are public opinion and psychotherapy. Social pressures must be redirected to discourage rather than promote the excessive indulgence that so often leads to pathological drinking. It is a matter of common knowledge that crossing this nebulous borderline is a one-way passage, that prevention as such is possible only up to a given point. Unfortunately such help as is now available is rarely enlisted before this fateful transition. The work of prevention lies in this prepathological area where the individual not only fails to recognize the direction in which he is headed, but prob-

ably would resist any therapy that might be offered. Education is our one present answer, not only for the individual but for his family, friends, employer, physician, anyone who might have an opportunity to help before it is too late. Basic to the success of such help is understanding—the realization that alcoholism is not just a disease in itself, but a symptom of deep emotional disturbance. Both the drinker and those whose lives are interwoven with his must recognize that alcohol is merely a substitute for other satisfactions. Once this fact is accepted, there may be an opportunity for psychiatry to operate in the prepathological area, concentrating on the more fruitful work of true prevention, rather than dissipating its energies on the lengthy, involved, and frequently hopeless task of rehabilitation.

NEWTON BIGELOW, M. D.

THE ISAAC RAY LECTURESHIP

Isaac Ray was one of the famed "original thirteen" who in 1844 founded the body that is now the American Psychiatric Association. He was also superintendent of Butler Hospital in Providence, R. I., and for the four years 1855-1859 served as president of the newly formed Association. He was a pioneer in forensic psychiatry and his book, *A Treatise on the Jurisprudence of Insanity*, published in 1838, was long the accepted source of authority in this field.

The Committee on the History of Psychiatry under the chairmanship of Dr. Gregory Zilboorg has had under consideration for years the possibility of establishing a lectureship to commemorate Dr. Ray's work. This hope is now realized, as reported by Dr. Finley Gayle as Secretary of the Association in his account of the Atlantic City meeting, appearing in the July issue of the JOURNAL (page 59). A committee on the Isaac Ray Award was appointed by President Bartemeier. The function of the committee is to select one person each year who is considered outstanding in the fields of psychiatry or jurisprudence to give a series of lectures in a university that includes both a medical school and a law school. The committee comprised five Fellows of the American Psychiatric Association: Drs. Frank J. Curran, chairman, George S. Stevenson, LeRoy Maeder, Paul Schroeder, and Frank J. Bracelan l; and two representatives of the legal profession, Mr. Ralph C. Busser and Mr. Walter A. Edwards.

Dr. Winfred Overholser, superintendent of Saint Elizabeths Hospital, Washington, D. C., has been nominated as the first recipient of the Award and will deliver the Isaac Ray Lectures at Harvard University under the sponsorship of the Faculties of the Law and Medical Schools of that university. The dates of the Lectures are November 13 and 14 in the Law School and November 17 and 18 in the Medical School.

"ARE ANTIVIVISECTIONISTS INSANE?"

The National Society for Medical Research has called attention to the lead article in the August 16 issue of *Collier's Magazine* dealing with the activities of the antivivisectionists. The article points out that these aggressive sentimentalists appear to have been losing their long and bitter fight against medical research involving animal experimentation. Not only medicine's campaign of facts but also the antivivisectionist's own activities, and irresponsible and indiscreet pronouncements, have contributed to their losing battle.

The author of the article referred to reports that in a poll conducted by the *Philadelphia Bulletin* 4 out of 5 antivivisectionist parents actually stated that they would not sacrifice a dog to save their own children's lives! One hundred percent of nonparent antivivisectionists declared that they would sacrifice a child before they would sacrifice a dog.

The National Society for Medical Research, of which Dr. A. J. Carlson is president, in a circular letter dated August 21 asks the question at the head of this comment and follows with another question: "Is their 'humanitarianism' a mask for their own bitter hatreds and vicious urges?" In order to let the public as well as the profession form their own opinions the National Society for Medical Research has published samples of antivivisectionist letters in a photo-offset leaflet entitled, "Fan Mail for Scientists," a copy of which may be had by addressing the National Society at 208 North Wells St., Chicago 6, Ill.

The viciousness, obscenity, and extravagant mendacity of many of these communications are almost incredible and cannot be conceived as emanating from balanced or wholesome minds.

In the letter addressed to the public Dr. Carlson comments:

> The recent murder of an 18-year-old secretary in the offices of the American Physical Society brought home to many of us that the so-called "harmless crackpots" are not always so harmless.
>
> Several years ago an antivivisectionist shot at, but did not hit, Dr. Harry Goldblatt, world-renowned heart specialist of the Cedars of Lebanon Hospital in Los Angeles.
>
> Recently antivivisectionists have threatened the lives of the Vice President and two members of the faculty of the University of Illinois.

Referring to the leaflet mentioned above, Dr. Carlson adds:

> We could not reproduce the most violent letters because the language is so vile that the resultant publication could not be sent through the mail.

It is well that the personality types that congregate under the antivivisectionist banner should be widely known.

AMERICAN INDIAN HEALING RITUALS

> If anywhere, then certainly among the primitives disease was not considered a private matter of the individual. It never is, but primitives were quite outspoken in looking at disease not only as a social sanction but also as a social responsibility. When a tribesman was stricken with severe illness, it was a misfortune that concerned the whole social group, and the family and sometimes the community joined in order to readjust the sick to his environment by common action. This is most graphically expressed in the Indian rituals of which those of the Navahos are perhaps the most highly developed. . . . . Ceremonies are lengthy affairs that last from two to nine days. The excitement is great when one is being prepared. . . . . There can be no doubt that treatments carried out for nine days and nights on such a high emotional pitch must give results in many cases, and not only of hysteria. The very unity of primitive medicine, the fact that it never addresses itself to either body or mind but always to both, explains many of its results also in the somatic field. That a ceremonial in the course of which the patient comes into complete harmony with nature and the universe must have a strong psychotherapeutic value goes without saying.
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> Sigerist: *A History of Medicine*, Vol. I.

NEWS AND NOTES

CAJAL CENTENARY.—The May-June 1952 issue of *Archivos Mexicanos de Neurologia y Psiquiatria* is dedicated to Ramon y Cajal and celebrates the 100th anniversary of his birth. This issue of the Archivos contains an interesting and little-known essay by Cajal, presented by Dr. J. Puche, in which the master speculates about the more satisfactory conditions of living in some future day when man shall have learned more about his own brain and possibly have become able to conquer himself.

Other articles in this issue are "The Importance of the Work of Cajal in Modern Neuropsychiatry," by Dr. Dionisio Nieto; "Recollections of Cajal," by Dr. I. Costero; and "The Role of Cajal in the Development of Scientific Activities in Spain and Spanish America," by Dr. Manuel Martinez Baez.

NEW BUILDING BUFFALO STATE HOSPITAL.—Formal dedication of a new 617-bed medical-surgical building at the Buffalo State Hospital is scheduled for October 14, 1952. The building was erected at a cost of $4,747,000 under New York State's $178,000,000 construction program, which will provide some 14,000 new beds in 17 institutions. Nearing completion are a 768-bed medical-surgical building at Binghamton State Hospital and a similar facility for 718 patients at Utica State Hospital. Other medical-surgical buildings in various stages of planning include a 1,200-bed unit for Manhattan State Hospital and a 1,030-bed unit for Rochester State Hospital.

NEW GERIATRIC JOURNAL.—The American Geriatrics Society announces that beginning in January 1953 they will publish their own official periodical to the called *The Journal of the American Geriatrics Society*. Dr. Willard Thompson, of Chicago, is president of the Society and will edit the journal. Dr. Malford Thewlis, of Wakefield, R. I., is permanent secretary. All physicians interested in diseases of the aging are invited to join the Society. The new journal will be published for the Society by the Williams & Wilkins Co., of Baltimore, Md.

"WHAT WE CAN DO ABOUT THE DRUG MENACE."—The Public Affairs Pamphlets, of New York City, announce the availability of a pamphlet by this title, written by Albert Deutsch. Because of widespread misinformation on the subject the publishers feel that this pamphlet will do much to bring full information on an exploited subject to a public that needs it. Price of the pamphlet is 18 cents apiece for 10 to 100 copies, and 16 cents apiece for 100 to 250 copies. The address of the publishers is 22 E. 38th St., New York 16. This is a nonprofit educational organization.

THE SALMON LECTURES 1952.—The Salmon Committee on Psychiatry and Mental Hygiene announces that Dr. Franz Josef Kallmann will deliver this year's Thomas William Salmon Lectures at the New York Academy of Medicine. His subject will be "Heredity in Health and Mental Disorder." The lectures will be given on the evenings of November 3, 10, and 18 at 8:30 o'clock.

Dr. Kallmann is Associate Research Scientist at the New York State Psychiatric Institute and Assistant Clinical Professor of Psychiatry at Columbia University. He was one of the founders and the first president of the American Society of Human Genetics and is a member of the Board of Directors of the American Eugenics Society.

FOURTH MENTAL HOSPITAL INSTITUTE.—The Fourth Mental Hospital Institute sponsored by the American Psychiatric Association will take place at the Deshler-Wallick Hotel, Columbus, Ohio, October 20-23, 1952. The program for this Institute was drafted on the basis of suggestions received at the Third Institute and in the light of the meeting of the Mental Hospital Service Consultants at Atlantic City in May.

The tentative program indicates that, as in former Institutes, practically all hospital activities and problems of hospital administration will be dealt with in lectures and discussions, in which delegates will participate.

DR. NEWDIGATE M. OWENSBY.—With deep regret we record the death on August 10 of Dr. Newdigate Moreland Owensby of Atlanta, Ga. Many members of the American Psychiatric Association will remember the annual meeting in Atlanta in 1929. It may not be generally known that it was mainly through the efforts of Dr. Owensby that the Atlantic City meeting was made possible.

Perhaps his most significant contribution to American psychiatry was the founding in 1935 of the Southern Psychiatric Association, which has promoted psychiatric interests throughout the southland as no other means could have done. This important and vigorous organization is Dr. Owensby's monument. The forthcoming meeting of the Southern Psychiatric Association will afford opportunity for paying tribute to the man to whom the Association owes so much.

SOCIAL WORK IN INDIA.—The March 1952 issue of the *Indian Journal of Social Work* is a special enlarged number reporting on the fifth annual session of the Indian Conference of Social Work, which took place in Calcutta, December 1951. The theme for discussion was "National Planning for Social Welfare," and among the topics considered were rural community development, industrial problems, administration and training in social work, and planning social defense. Prime Minister Nehru addressed the Conference; he stressed the fact that social work must have the individual as a nucleus and encourage people to help themselves. As to India's population problem, he felt that this had been exaggerated somewhat: "Even now India has not got the density of population of Western Europe." He stated, however, that India must of course restrict population, because more population means low standards.

Included among the speakers at the Conference were Professor William F. Ogburn of the Department of Sociology, University of Chicago, and Dr. Walter C. Reckless, professor of criminology, Ohio State University, who was in India as a United Nations Technical Assistant to organize a special training program for jail officers at the Tata Institute of Social Sciences.

RESEARCH IN SCHIZOPHRENIA.—The Washington School of Psychiatry announces a grant of $25,000 from the Social Research Foundation, Inc., of New York City, for a research project to be directed by Dr. Frieda Fromm-Reichmann.

Dr. Fromm-Reichmann is chairman of the Council of Fellows in the Washington School of Psychiatry and director of research at Chestnut Lodge Sanitorium, Rockville, Md. The project will be oriented along psychoanalytic lines.

DR. CLARENCE H. BELLINGER.—The American Psychiatric Association has suffered a notable loss in the death on August 12 of Dr. Clarence H. Bellinger, senior director of Brooklyn State Hospital. Dr. Bellinger had been in the service of the New York State Department of Mental Hygiene 42 years and had directed the Brooklyn State Hospital since 1935. He was regarded as one of the most progressive and efficient hospital directors in the service and most versatile in developing new procedures and activities to promote the welfare of his patients.

He was a valued medicolegal expert and since 1937 had also served as professor of psychiatry at the Long Island College of Medicine. For a number of years he had been a most helpful member of the budget committee of the Association.

AMERICAN SOCIETY OF HUMAN GENETICS.—The fifth annual meeting of the American Society of Human Genetics, which is an affiliate of the American Institute of Biological Sciences, took place September 8-10, 1952, at Cornell University, Ithaca, N. Y. In addition to individual papers dealing with various aspects of the subject there were 4 symposia: "The Genetics of Various Constitutional Defects," "Light from Animal Experimentation

on Human Heredity," "Counselling Clinics in Human Heredity," and "Nomenclature in Human Genetics." Dr. Franz J. Kallmanns' presidential address was entitled "Human Genetics as a Science, as a Profession, and as a Social-Minded Trend of Orientation."

CONGRESS IN CHILE.—The Chilean Society of Neurology, Psychiatry, and Neuro-Surgery announces an International Congress of Neuro-Psychiatry to be held in Santiago, Chile, December 9-15, 1952, in conjunction with the celebration of the centenary of the founding of the National Mental Hospital of Chile. A broad program is being planned, and among the topics to be discussed are virus infections of the nervous system, psychomotor epilepsy, organization of mental hospitals, relations between neurology and psychiatry, disturbances of consciousness, convulsive states, neuroses, biotype and personality, and psychopathic personality.

Dr. Winfred Overholser, superintendent of Saint Elizabeths Hospital, Washington, D. C., has been invited to address the Congress on the following topics: undergraduate and graduate psychiatric education, modern trends in psychiatry, and the mentally deviated sexual offender.

The President of the Society is Dr. Octavio Peralta V., and the Secretary General, Dr. Armando Roa R. These officers may be addressed in care of Casilla 2677, Santiago, Chile.

AMERICAN PSYCHOSOMATIC SOCIETY.—The tenth annual meeting of the American Psychosomatic Society will be held at Chalfonte-Haddon Hall, Atlantic City, on May 2 and 3, 1953.

The program committee would like to receive titles and abstracts of proposed papers by December 1, 1952. The time allotted for the reading of each paper will be 20 minutes. The committee is interested in investigations in the psychosomatic aspects of all the medical specialties, and in contributions in psychophysiology and ecology. There will be one panel devoted to the adrenal cortex. Accepted papers will be submitted to the editorial board of *Psychosomatic Medicine* for possible publication in the Journal.

Material for the program committee should be sent, in duplicate, to Dr. Sydney G. Margolin, chairman, 551 Madison Ave., New York 22, N. Y.

AMERICAN ASSOCIATION OF REHABILITATION THERAPISTS.—The third annual clinical conference of this Association was held at the Hotel Statler, New York City, September 2-5, 1952. Leading physicians in the field of medical rehabilitation delivered addresses, including Henry S. Kessler, West Orange, N. J., Temple Fay, Philadelphia, Pa., Edward E. Gordon, New York City, George G. Deaver, New York City, and Arthur S. Abramson, New York City.

A tour of 4 rehabilitation centers in the metropolitan area was conducted for members attending the annual meeting from all parts of the United States.

MASSACHUSETTS POSTGRADUATE SEMINAR.—The Massachusetts Department of Mental Health announces the 18th Postgraduate Seminar in Neurology and Psychiatry, in two parts. The first is a review course in basic neurology and psychiatry, at the Metropolitan State Hospital, Waltham, Mass., consisting of 70 lectures on Mondays from 2 to 8:30 p.m., from October 6 to December 8, 1952, and from March 2 to May 4, 1953. The second is a course in child psychiatry (pediatric neuropsychiatry) at the Walter E. Fernald State School, Waverly, Mass., consisting of 18 lectures on Tuesdays from 6 to 9:30 p.m., October 7 to December 9, 1952.

EUGENE BLEULER'S "DEMENTIA PRÆCOX."—The International Universities Press has recently published a synopsis of this work, written by Dr. Nathan S. Kline of Worcester State Hospital (Mass.). In these days of "Digests" this condensed version of Bleuler's important monograph should be welcome to those who may not have access to the original and may wish to review its essential features. The brochure is available at a price of $1.25.

BOOK REVIEWS

A Handbook of Psychosomatic Medicine with Particular Reference to Intestinal Disorders. By *Alfred J. Cantor, M.D.* (New York: The Julian Press, Inc., 1951. Price: $5.00.)

The author, a specialist in gastroenterology and proctological surgery, is trying in this book to promote the integration of the medical, surgical, and psychological aspects of medicine.

The content is divided into 2 sections: The one (83 pages) deals with the prevailing concepts of the meaning, scope, and treatment of psychosomatic medicine. The other and major part (over 200 pages) is concerned with the gastrointestinal tract and a brief survey of the function of the autonomic nervous system. Dr. Cantor does not claim to present original work. His aim is to synthesize knowledge of various disciplines relevant to psychosomatic medicine.

The chapter on "General Semantics" will be appreciated by the reader who cannot afford the time to delve into the monumental and not easily digestible work of Korzybski. It is a concise but sufficiently informing presentation of how words may strongly affect patients in provoking reactions, as if the words were not symbols of things but the things themselves. Patients are, therefore, taught to realize that words, as symbols, may have different meanings; consequently, their reactions to words are bound to be different; above all, their reactions should derive from the integrated action of both emotions and thoughts. In passing, the reviewer regards as undue simplification the author's topography of the "emotional zone in the thalamus" and the "intelligence zone in the cortex."

Of greater and more practical importance is the regrettable omission to remind ourselves that too frequently inappropriate words by physicians have ill effects on their patients.

"The Silent Level" is the heading of another chapter. Its essence is expressed in the following quotation: "Occasionally during conventional analysis the patient will relive a situation of emotional conflict and will burst into tears. There may be rage or other affect. At these points the patient has touched the silent level. In such a case the therapy will be more effective. It is my contention that adequate therapy can only be achieved (or is mainly achieved) at the silent level."

"Guided association analysis," recommended by the author for the treatment of psychosomatic illnesses includes enlightenment of the patient that symptoms may be produced by emotions and a search for those emotional factors that are responsible for the psychosomatic illness. "The patient is asked to lie down on a couch or examining table and the physician sits by him. The patient is instructed to close his eyes and relax." In this setting the patient is encouraged to recount his past life experiences. Here, again, the author reminds us that the "emotional catharsis, by repeated reliving of the painful episodes, is the most important phase of therapy."

The major part of the book presents a survey of the literature and the author's own experience with psychosomatic disorders of the gastrointestinal system. More space is allotted to "ulcerative colitis" than to any other disease of the gastrointestinal tract. This is as it should be, considering the fact that the etiology of this illness is obscure and that the particular etiological significance of emotional disturbances has not been adequately established. The author, therefore, appears to me fully justified to emphasize the medical aspect: "Until such time as we are provided with a better understanding of the psychiatric aspects of ulcerative colitis, we would do best to consider psychiatry an adjunct therapy." I like to add that psychotherapy for being "adjunct therapy" is no less indicated, particularly in the less acute phases of the illness or in the periods of remissions.

Dr. Cantor, not being a psychiatrist, deserves the more credit for this very enlightening exposé of the validity of the psychological aspect in medicine.

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Sex and the Law. By *Judge Morris Ploscowe.* (New York: Prentice Hall, 1951. Price: $3.95.)

"It is possible for a psychiatrist," says Judge Ploscowe, "to designate almost anybody a sex psychopath. The psychiatrist is not hampered by such matters as the rules of evidence or the necessity of proving a case beyond a reasonable doubt." This is, unfortunately, too true. In the anxiety generated by problems of sexual misconduct, legislators and judges have sought to get rid of this difficult problem by turning the matter over to psychiatrists. Few jurists have recognized that it is sociologically sensible to distinguish between the relatively harmless, or at most "nuisance" category of sex offenders, and the dangerous or "menace" classification. Judge Ploscowe makes that distinction and properly pleads for legislation that will avoid the enormous effort of entangling minor offenders in the combined judicial-psychiatric machinery. He recognizes, as many legislators do not, that the psychiatrist does not have all the answers to this problem; that the state hospital is not an appropriate place for most nonpsychotic sex offenders; and that what is needed is a new kind of institution half-way between the prison and the hospital. He points out the weaknesses of most of our present sex psychopath laws, citing cases at each extreme that will make the reader shudder. On the one hand there is life imprisonment in a locked-ward hospital for a man found urinating behind a tree,

simply because no state hospital superintendent would certify that this person (or any person) will never get into sexual difficulty. On the other hand, he cites cases of very dangerous offenders who escape prison because sexual psychopathy is construed as a "sickness" and who then have to be discharged from overcrowded state hospitals because they have attained maximum hospital benefit. While Judge Ploscowe does not have the answer either, he writes several thought-provoking, example-filled chapters on the subject.

The book also reviews the laws of marriage, divorce, illegitimacy, annulment, sexual perversion, rape, and prostitution. In most states a psychotic person who, by the simplest of tests and for the briefest of times, is "competent" is allowed to marry. Judge Ploscowe deplores this and applauds the Michigan law that forbids anyone who has ever been a patient in a public institution for mental defectives from marrying until he is cured of his mental deficiency. Since ex-patients of private schools for mental defectives are not subject to this ban, and since mental defectives at certain grades may make perfectly adequate husbands and wives, it is difficult to share the author's enthusiasm for this kind of statute. There is a discussion of psychic impotence as grounds for annulment or (on the theory of "constructive desertion") as grounds for divorce. The book is filled with incidents and examples, some funny, some sad, of the meaning, and sometimes the absurdity, of existing law. The Judge writes smoothly and readably, though scarcely objectively. However, his subjectivity is well meant and in most cases he is on the side of the angels. And every time he highlights the inadequacy of the law, he follows this up with a constructive suggestion.

The Judge belongs to the school of those who want to make it harder to get married. Apparently he does not agree with St. Paul that "it is better to marry than to burn," because he is not bothered by the certainty that, if it were harder to marry, there would be more extramarital and premarital fornication. "Such sexual behavior." says the Judge, "will be a lesser evil than the subsequent dissolving of unwise or immature marriages." And, as he sees it, there is another advantage to tighter laws on marriage eligibility. "If husbands and wives were required to choose their mates more carefully," he says, ". . . if the law made certain that the choice was a free one, after mature reflection, there would be less likelihood of incompatible matrimonial alliances." Wanna bet?

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OCCUPATIONAL CHOICE, AN APPROACH TO A GENERAL THEORY. By *Eli Ginsberg, Sol W. Ginsburg, Sidney Axelrad, John L. Herma.* (New York: Columbia University Press, 1951. Price: $3.75.)

The study this book reports was designed in the framework of an inquiry into the conservation of human resources, which had been carried on by the senior author for some time, so that it was preceded by several studies on unemployment and occupational adjustment. The keynote of the present investigation hence lies in the awareness of the waste of resources consequent to the way vocational decisions are achieved at the present time. Existing theories hold that individuals make decisions about their future vocation "accidentally," that is, in response to the opportunities to which they happen to be exposed without much individual option. On the other side psychoanalytic observations suggest that the individual's vocational choices are meaningful mainly as the effect of unconscious needs. In the practice of vocational counseling a pragmatic combination of both viewpoints has developed without leading to a systematic theory. Thus the major objective of this book was to develop such a theory, "so comprehensive as to permit the identification and analysis of the major factors in the decision-making of the individual." The fluid relationship between vocational guidance and general guidance merging into psychotherapy is noted at this point.

The choice of occupation is viewed as a "chain of decisions," as a "developmental process in which past behavior exercises the major influence upon present and future decisions." The interview material upon which the study is based was, first, organized into attitudes toward the self and its capacities, the individual's interests and their changes, his goals and values as they relate to work and his "time perspective," that is, the period when he begins to relate the schedule of his vocational career to the schedule of his life. The second major aspect of the study was concerned with the realities of the individual's life, his family, education, work environment, and personal life plan. The third major category dealt with "key persons" influential in resolving (or creating) the natural ambiguities of vocational choice. In order to obtain some workable generalizations at a relatively early stage, and lest the investigators be overwhelmed by the complexities of the problem of vocational decision at large, a relatively uniform population of urban, white, Protestant-or-Catholic subjects was selected, all belonging to the upper ranges of the middle class, undisturbed by disruptive events in the family and personal pathology and regularly distributed over the age space from 11 to 24 years. Equal distribution of science and engineering against humanities and social study interests on the college level was attained, too. As an informal control a group of boys from a distinctly lower-income group, and a group of upper middle-class college girls more likely to marry than to seek a career, were included in the study.

Three major steps in the development of vocational goals were discerned: the first period, roughly from 6 to 11 years of age, largely dominated by personal wishes and phantasies; a subsequent one from 11 to 18 when tentative choices are undertaken; and the period following when realistic choices have to be made. The transition from the first, as it were, naturally autistic stage, when need-tensions are being solved through a not yet clearly differentiated global effort of wish-fulfilling phantasy, is brought by an increasing grasp of reality and

by simultaneous external pressures. The period of "tentative choices" that follows was observed in 4 developmental steps. Equally does the final stage of "realistic choices" show a structure of its own: "exploration," when the individual looks for information about various vocational possibilities, followed by "crystallization," when the individual becomes capable of assessing the factors that influence his choice well enough so that he can commit himself to it. In the last stage ("specification") he has to decide for a more specific direction in the general area to which he had turned before.

Individuals crystallize their choices "by becoming aware of their propensities." The development of an unswerving attitude toward one's vocational goal is one criterion of having reached that stage. Even when vocational choice seemed definite, however, a closer inquiry sometimes showed what the authors call pseudocrystallization in individuals intent on going into a certain direction on unrealistic grounds. The patterns that had been observed and found valid among the subjects of the study were, of course, subject to variations significantly greater during the period of realistic choices than during that of tentative choices. The early stages of decision-taking were in some cases narrower, in others wider than what the trend of the group held. On the other hand, some individuals were unusually early, others unusually late in making their decisions. One of the reasons for "narrow" range was the presence of special talent, which in turn was usually encouraged by other people; another was early work experience. People who have a narrow range of choice that is at the same time met by good opportunities of training tend to "crystallize" early. Others may cling to an early unrealistic choice out of fear of the unknown. Late choices and marked deviations in attitude toward vocational adjustment at any age level were found to be related to an unresolved dependence on parental figures. The individual continued to be directed by powerful phantasies that were as little adapted to reality as were their needs for dependence. These findings were then compared with the sample derived from the lower income group along with that of the upper-income group of young women.

The general theory that emerged from these observations is that vocational choice " . . . . is a process; the process is largely irreversible; compromise is an essential aspect of every choice." This formation also implies the general direction of this study: it is group-minded, intent on trends and patterns, sociological in its basic emphasis. The merits of this approach are plain: vocational choice is fundamentally a social problem and no amount of individual hypothesis will make sense if it is not set up in a framework that integrates it with the functioning patterns of social systems. Nor can the social urgency of such a project be stressed enough. "Conservation of resources" as an orbit of concern cannot be drawn widely enough. "Waste" means the destruction of resources to the detriment of all. But it has another dimension too: it means impoverishment, restriction, self-perpetuated suffering. Heedlessness and confusion in this as in other fields of social interaction mean individual and social pathology. An industrial civilization cannot afford to let its young members flounder without knowing more about their most vital decision but that occupational choice is much more difficult now than it used to be. Therein lies the paramount significance of understanding the determinants of vocational choice for the social sciences and psychiatry. In this respect the book is an important contribution. If its limitations are mentioned, credit must be given at once to its authors for knowing about them and discussing them freely. The authors observe: "Our general theory of occupational choice does not make adequate provision for emotional determinants." For the present study the omission is planful and they profess to be as anxious as the reader may be, to see it corrected through further investigation. Notwithstanding this position, what I have missed most in the present study is the organizatory benefit of psychological theory, such as psychoanalytic ego-psychology, which would offer a systematic framework to the inchoate integration of many factors in the individual's experience into an abiding social function. There should also be a greater and more clearly structured array of data to which the events of regular vocational development (or its deviations) could be related. For instance, what is the relationship of "pseudocrystallization" to individual traits and to family constellations beyond the generalizations cited before? The professional reader can envisage the tantalizing decision the authors must have faced, between writing about vocational adjustment for all who need to know about it, or primarily for specialists, and then with a warrant for concentration and compression as the familiarity of the reader with basic concepts and methods can be taken for granted. In spite of a painstaking effort to be explicit throughout there is no clear vision of the details of the study: case examples are not as illustrative and telling as one would want them to be, the method of the study remains implicit, and while theory is evolved slowly and cautiously, it does not always relate succinctly and sharply to the data of observation. In other words, the study suffers in conciseness and stringency for what it gains in the breadth of appeal. Some of the most important and most stimulating statements are relegated to concluding chapters on "Occupational Choice and Work" and on the "Conservation of Human Resources," when the impact of these ideas should have been felt in all the preceding chapters. Altogether, one will be waiting eagerly for further studies to carry on with what in agreement with the authors one will regard as the necessary extensions of this auspicious beginning.

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AN EXPERIMENT IN THE PREVENTION OF DELINQUENCY. By *Edwin Powers and Helen Witmer.* (New York: Columbia University Press, 1951. Price: $6.00).

This 650-page volume constitutes a very complete report of a most important, thorough-going, and

ground-breaking enterprise in constructive endeavor with young delinquents. The study was suggested by the late Dr. Richard Cabot, evoked by the rather discouraging outlook inferable from the Gluecks' "500 Criminal Careers," with reference to treatment and prevention in this field. It was Dr. Cabot's thought that perhaps the very special and studied emphasis on the humanistic element over a long period in the total approach might have promise. As he put it, in all instances familiar to him "there has been at least one necessary condition: that someone should come to know and to understand the man in so intimate and friendly a way that he comes to a better understanding of himself and to a truer comprehension of the world he lives in,"—that is, in the proper sense and with other appropriate implementation, the principle of maintained "friendly understanding."

The material of the study comprised 2 original groups of 325 probable predelinquent boys from the Cambridge-Summerville areas. One group, taken as the experimental or treatment group, was given the benefit of the fullest follow-up and counseling attention. The other was taken as a control series in the sense that the very special services rendered the first group were not here afforded. The median age at the beginning of treatment was 10½ years and the median treatment period about 5 years. Special emphasis, as intimated, was placed on the counseling personnel, which included a considerable number of individuals of varying backgrounds and personal qualities. Primary stress was given the establishment of functional human relationship as opposed to the "human engineering" or overtechnical "professional" and less personal type of approach.

As to results, considering the broad nature of the project with the many intangible facets involved, not too much can be briefly stated in absolute, specific terms. However, certain general findings were strikingly manifest. For one thing, the highly personalized type of contact here employed did seem in the main to be productive of positive effects. Also it became apparent that, aside from technical qualifications, the element critical to favorable results was the personality and makeup of the individual counselor and the degree of warmth and humanity characterizing his or her continuing contact. Incidentally, the counselor achieving the greatest measure of effectiveness was a nurse without formal training in social work.

In addition. as is being pointedly stressed at the present time, notably by Bowlby, the critical importance of emotionally inadequate home and family relationships and dynamics with respect to delinquency patterning stands out in strong relief. Further, as stated by Professor Allport in his very helpful foreword, the experiment "tells us that treatment efforts of the type employed here will probably not prevent a boy, beset by poor home and neighborhood—and headed in an antisocial direction—from drifting into delinquency. But the counselor's efforts may take effect after the boy has been burned. The boy must learn, in part, from hard experience. *He then learns more surely if he has had the benefit of friendly precept and example.*"

The report is emminently functional, clear, frank, and open in both its philosophic and practical bearings. It is thoroughly documented and makes most stimulating reading, impressing the reviewer as a highly significant contribution pertinent to therapy as a whole as well as that aspect relating to delinquency and its management. Without reservation, it is recommended in the strongest terms to all interested, lay and professional.

T. R.

ATLAS OF CROSS SECTION ANATOMY OF THE BRAIN. Guide to the Study of the Morphology and Fibre Tracts of the Human Brain. By *Emil Villiger, Eugen Ludwig, and A. T. Rasmussen.* (Philadelphia: The Blakiston Company, 1951.)

Professor A. T. Rasmussen of the department of anatomy, University of Minnesota, has produced in this volume a valuable revision and enlargement of the Fifth Section of the Fourteenth Edition of Emil Villiger's "Brain and Spinal Cord."

Dr. Rasmussen has added to the earlier illustrations the main subdivisions of the thalamic nuclei, using the terminology of E. A. Walker and R. L. Crouch. He has also added illustrations of a valuable series of Weigert-stained parasagittal sections of the human brain, which will be particularly useful in clarifying the course and relations of the long conducting tracts in the brain stem.

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THE MIND AT WORK AND PLAY. By *Sir Frederic Bartlett, C.B.E., M.A., F.R.S.* (Boston: The Beacon Press, 1951. Price: $2.50.)

In his *The Mind at Work and Play,* Sir Frederic Bartlett, professor of experimental psychology at Cambridge University, has written a valuable and readable book. Experimental psychology, now unfortunately at the full swing of the pendulum of disfavor, as far as most psychiatrists are concerned, was once thought to be indispensable for the more completely trained alienist. Experimental psychology still remains the normal training for the clinical psychologist. (This suggests the somewhat malicious thought that this may be fortunate for the psychiatrist. So long as the clinical psychologist is fettered with rat-statistical psychology at the expense of the study of man and the humanities, there is little likelihood of his becoming a serious rival.)

The Mind at Work and Play belongs to a new trend in writing. The Penguins, Pelicans, Mentor Books, and other books representing this trend have all arisen of late to meet a contemporary need and may be described as books written by specialists for other specialists. For it is a fact that in this age of intense intellectual one-sidedness there remains precious little extra time for the specialist himself to sample other areas and kinds of knowledge unless it is concentrated in capsule form. Hence it is

characteristic of this new style of writing that it be authentic, clear, fresh in its approach and that it distill a large subject within a small volume. Thus, as one skims through Sir Frederic's book, a book with such homely, unpretentious chapter titles as "The Mind Observes," "The Mind Remembers," "The Mind Thinks," it is not evident at first that one has been skipping gingerly over such thin ice as field theory and other profound and debatable topics. In such a chapter as "The Mind Thinks," Sir Frederic covers such items as the transfer of training, intelligence and thinking, gap-filling, interpolation and extrapolation, thinking, and training the mind to think. The language is often deceptively simple: "Filling a gap is, generally speaking, the most important thing that anybody does when he thinks" or, "When a person remembers anything, he is using information which he has picked up from one set of circumstances to help him in dealing with another set"—to take samples at random.

It is not unlikely that the 142 pages of this easily read book compress about all that the average—not average man, but let us say "average specialist, not an experimental psychologist"— will want to carry around as permanent mental furniture in this area. It is hoped that there will be more of this type of science writing, which may fairly be described as humanistic literature; science, not for war, nor for economic production, but as a cultural enterprise. A refreshing novelty in this book, it should be added, is that all the experiments, one is tempted to say, can be conducted anywhere save in a laboratory: in the living room, on the bus, or even during one's vacant moments crossing a field. Nostalgically this suggests a gentler and more genial chapter in the earlier history of science, when science was still in the hobby stage, the private toy of intellectual dilettantes. This book, however, is solid and according to its Preface represents the pooled suggestions of almost the entire research and workshop staff of the Cambridge Psychological Laboratory.

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ESSAYS IN APPLIED PSYCHOANALYSIS. Vol. I: Miscellaneous Essays; Vol. II: Essays in Folklore and Religion. By *Ernest Jones, M.D.* (London: The Hogarth Press, Ltd., 1951. Price: 21s. each).

In these 2 volumes the author has collected 36 contributions, the majority of which had been published previously with publication dates ranging from 1911 to 1949. Several of the papers were read at society meetings but not published. The forerunner of this work, a single volume with the same title, appeared in 1923. It has been expanded to the present 2-volume edition to include the material accumulated since.

Volume I includes a wide sweep of topics in which the author makes application of psychoanalytic theory mainly to subjects other than clinical—political psychology, nationalistic attitudes, war, Quislingism, anti-semitism, evolution and revolution, suicidal fantasies, artistic expression, the psychology of chess, and other themes. One of the essays, "How can civilization be saved?" was read at a symposium held by the Federation of Progressive Societies shortly before the outbreak of World War II.

Volume II contains papers dealing with folklore, anthropology, and religion, especially the latter; at least 7 of the essays deal with various aspects of religion, chiefly the Christian religion.

Ernest Jones is a versatile and erudite investigator, and his studies extend over an extraordinarily wide domain. Indeed the field to which he applies psychoanalytic theory is as he puts it "almost indefinitely large." Agreement with many of his analyses and conclusions will of course depend upon individual attitudes to Freudian doctrine. In considering cause-and-effect relationships it seems safe to assume that illness of the individual, social upheaval, "crazes," war, the growth of religious systems, all represent human reactions not to one but to a combination of many factors. Similarly, in explaining human conduct no single discipline, whether biology, anthropology, sociology, or psychology, has all the answers. Critics of psychiatry have sometimes referred disparagingly to such an implied omniscence, which it should not be necessary for psychiatry to disclaim. A possibly relevant statement occurs in Jones' essay, The Psychology of Religion: ". . . the religious life represents a dramatization on a cosmic plane of the emotions, fears and longings which arose in the child's relations to his parents." As if to anticipate the reader's question of so simple an answer, he adds, "This is a sentence which must remain without much meaning for those who have not taken cognizance of the modern study of the unconscious mind, but it is pregnant for those who have." Further on in studying the Christian religion he demonstrates in scholarly fashion the debts of Christianity to earlier pagan systems.

One of the most interesting essays is a detailed and ingenious dissertation on the Catholic legend of the Madonna's conception through the ear by the breath of the Holy Ghost. St. Augustine wrote: "Deus per angelum loquebatur et Virgo per aurem impraegnebatur." The author discusses this Christian myth in the light of numerous kindred stories from other mythologies. The Holy Ghost him(her)self he disposes of psychoanalytically in a separate study, in which he accounts for the curious fact that the Christian trinity consists of Father, Son, and a vague third party, the Holy Ghost, instead of Father, Mother, and Son, as in any natural family, human or divine, as exemplified by the Egyptian trinity, Osiris, Isis, and Horus. Jones' acquaintance with folklore, mythology, and comparative religion is far-reaching as this series of intriguing essays abundantly testifies.

But students of Shakespeare may be pardoned if they raise an eyebrow at his exegesis of Hamlet. In one of the papers he deals with the death of

Hamlet's father, brought about, as that father's ghost reports, by his brother, who poured into the porches of his ears the "juice of cursed hebona." Jones states that "the ear is an unconscious equivalent for anus. . . . So we must call Claudius' attack on his brother both a murderous aggression and a homosexual assault." When next you see this play it will perhaps be more comfortable to repress that bit of information. Then there is the mystery of Hamlet himself. This is not directly considered in the present volumes, as the author has expanded the subject elsewhere at book-length, "Hamlet and Oedipus." (If in some part the extravagances and distortions of the Olivier film are thence derivative then that sin must be laid at the author's door too.) If the play-goer is profoundly affected by the drama it "can only be because the hero's conflict finds its echo in a similar inner conflict in the mind of the hearer . . . the hearer himself does not know the inner cause of the conflict in his mind." With both hero and hearer ignorant of the motivation of Hamlet's behavior it is comforting to learn that even Shakespeare was also in the dark. "We thus reach the apparent paradox that the hero, the poet, and the audience are all profoundly moved by feelings due to a conflict of the source of which they are unaware." It remained for Ernest Jones to pluck out the heart of Hamlet's mystery. It seems a pity that the Bard didn't live to hear about it.

Of particular interest is the contribution, "The Symbolic Significance of Salt." Here the author has assembled a vast deal of data with references to a great variety of sources indicating the importance of this substance in folklore, superstitions, customs, and religions of all times and places. Many common forms of speech testify to the ubiquity of this preoccupation with salt—"Ye are the salt of the earth"; "cum grano salis"; "salt of truth"; Attic salt; to catch a bird, throw salt on its tail; to partake of one's salt (hospitality, friendship); "trust no one unless you have eaten much salt with him"; to sit above the salt (rank at table); wages were paid in Greece and Rome with salt (*salarium*, salary), hence "to earn one's salt," "not worth one's salt"; salt as a symbol of sanctity: holy water is salted in the Catholic Church, the Inquisitors of Pope Innocent VIII carried salt with them for protection against the emissaries of Satan when they were presiding at the "examination" (torture) of persons accused of witchcraft; spilling salt an ill omen. Many of the symbolic relationships of salt are worked out by the author in considerable detail.

The essays in these volumes raise many questions and offer many answers. They present topics many of which, such as superstitious beliefs, the careless reader may simply take for granted or dismiss as trivial but which the literate person must consider, for their understanding insofar as that may be possible contributes to the understanding of human attitudes and behavior. "A psychology of religion, for example, is impossible without an understanding of superstition."

C.B.F.

THERAPEUTIC STUDIES ON PSYCHOTICS. By *Julius I. Steinfeld, M. D.* (Des Plaines, Illinois: Forest Press, 1951. Price: $3.50.)

This volume contains 4 papers that summarize the author's personal experience and theories gained from the treatment of psychotic patients over the past 32 years. In the first paper, "The Significance of Transference—Countertransference in the Treatment of Psychotics," the writer displays a considerable flexibility of method in handling the transference and countertransference. Instead of trying to be a neutral figure or of playing a detached, intellectual, or objective rôle, he attempts to adapt his behavior to the individual patient and the individual situation. The therapist becomes a kind of mediator between the demands of reality and the libidinous demands of the patient. The psychotherapist's job is conceived of as similar to that of the artist. He must be guided by intuitive and sympathetic understanding of the patient. A community of feeling is established between the therapist and the patient and thus the patient develops security. On this basis he is able to work through to objective relationships in a more realistic manner. In this deep relationship between the therapist and the patient the therapist may adopt a variety of roles, for example, the father or the mother at an Oedipal or pre-Oedipal level. As soon as the patient has been relieved of overwhelming id impulses, work on the ego level is begun, and here the therapist attempts to supply a new source of energy, for instance, in the form of a loving father, so that the patient through the processes of introjection and identification may strengthen his ego and release energy for integrative and objective functions. Fourteen cases, mostly of schizophrenia, are reviewed in some detail to illustrate the application of the author's methods. In some of these insulin or electric shock treatment was used in addition to psychotherapy for the purpose of contributing to the transference relationship according to the therapeutic indications of the moment. This paper is full of penetrating insights expressed by a man who has deep convictions about the nature and value of his own work.

The second paper, "Modified Methods of Electro-Shock Therapy," expands the material of the first, but with an emphasis upon the use of electroshock therapy as a means of contributing to the main psychotherapeutic job. Thus a patient who has produced a wealth of analytic material without improvement may be given an organically induced amnesia with shock to supply a breathing spell from overwhelming id impulses. In this breathing spell a positive transference may be established with the therapist. To establish a satisfactory transference in a deeply regressed patient it is frequently necessary for the therapist to be present when the patient awakens from a shock treatment. At this time he accepts and reciprocates the patient's demonstrations of affection. Shock therapy is also used to allay excitement, to overcome deep depressive and suicidal thoughts, and to shorten the time of treatment. The author presents some statistics on 500 cases, showing degrees of improvement,

the time of hospitalization, and discusses the application of ambulatory shock treatment. His figures show an 86% improvement sufficient to warrant patients' discharge from the hospital. The average hospitalization period was 33 days. About two-thirds of the patients came back for ambulatory treatments covering a period of 2 to 12 months.

The use of testosterone propionate with 24 female patients is described in the third paper, "Restricted Use of Male Sex Hormone for Chronic Female Patients." The chief indications for this drug were severe vasomotor phenomena of the menopause, accentuation of psychotic symptoms at the time of the menstrual period, and to increase excitability of the clitoris in cases of frigidity. Here, as in the case of shock treatment, the drug was used to contribute to psychotherapy.

"Further Studies in the Therapeutic Value of Acidosis in the Treatment of Psychotics" is the title of the fourth paper. The author presents data to show that there is a reduction in blood pH after shock treatment. Acidosis is felt to be an important factor in the therapeutic mechanism of convulsive therapy. Cases that are resistant to treatment may not have had a sufficient lowering of the blood pH. Here multiple shocks may be successful. Also, shock treatment is more effective if an acidotic condition is created by starvation or by a carbohydrate-free diet. In support of the hypothesis that the pH level of the blood has a relationship to the mental state, the author mentions the use of CO_2 inhalations, which alter the mental state, that epileptic seizures, which also affect the pH, result in improvement in schizophrenia, and that diabetes, which is associated with acidosis, is apparently incompatible with schizophrenia. Alcoholic patients do not show a reduction in pH with shock and in them shock is ineffective.

The book is well written and provides a stimulus to thought. Questions concerning the scientific validity of the author's theories may be raised, but the job of the therapist is to use intelligently whatever means are at his disposal.

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THE DYNAMICS OF PSYCHOLOGICAL TESTING. By *Milton S. Gurvitz.* (New York: Grune & Stratton, 1951.)

In keeping with the aim to present precisely how the psychologist uses tests, this volume is organized in a novel fashion. Most of the book is devoted to the presentation of all 17 cases that the psychologist tested during a single month. They had been referred to the author by the therapists because they were diagnostic problems. The psychological reports he supplied to the therapist were prepared independent of knowledge of the case histories.

The introductory statement concerning the psychologic procedures, specifically how the Wechsler-Bellevue, Rorschach, and Draw-A-Person are used and interpreted by this psychologist, is useful only for this purpose. It is too short a presentation to be useful independent of the rest of the book.

After this short introduction the cases were presented in the following order: "(1) the problem which the case presented, (2) complete protocols of the tests, (3) analysis of the protocols, (4) original 'blind' reports with evaluation by the therapist of each assertion in the report, (5) case history and (6) critique of the report in the light of the case history and evaluation of the therapist."

The case presentations are done with considerable clinical acumen, although the inevitable disagreements that other psychologists would have with the interpretations offered are also to be found. The interpretations show that the author is an experienced clinical psychologist working in a psychoanalytic tradition. For a description of how one such psychologist works this book may be recommended. The book closes with a statistical evaluation based on an analysis of the psychologist-therapist degrees of agreement and disagreement and general interpretations and conclusions.

The most disconcerting implication of this volume to this reviewer is that the psychologist's findings apparently are to be judged almost exclusively by the extent to which they agree with the therapist's already formed, independent interpretations. This method of evaluation is inherent in the organization of the case presentations. Each psychological report is interspersed with statements by the therapist, which he inserted upon reading them. In other words, after each major statement of the psychologist, the therapist would make a short comment. The great majority of these comments consist of nothing more than the two words, "I agree." Hardly ever is there anything in the therapist's comments to show that some new conception, some novel way of viewing the patient has been brought about by the psychologist's efforts. New vitality, different vistas, and added perspectives as results of the psychological report would appear to be a better criterion than the extent of agreement with the therapist. That these cases were seen after they had been under treatment for some time reduced the chance of new and different conceptualizations of dynamics, but the nature of the comments lead to the impression that the psychological reports were rather empty of any meaning that led to action on behalf of the patients.

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INTRODUCTION TO MURDER. By *Wenzell Brown.* (New York: Greenberg Publisher, 1952.)

During the summer of 1949 the "Lonely Hearts" murder trial attracted international attention because of the unique circumstances surrounding the murders and the vivid details of the sex activity of the 2 defendents in the case; and although Martha Beck, a 29-year-old divorcee, and Raymond Fernandez, a 34-year-old married man, were found guilty of killing a 66-year-old widow, this book attempts to throw doubt on the justice of sending them to the electric chair. Mr. Brown, who is obviously a professional writer, does a very good job of reporting but, evidently, is somewhat blinded by his own prejudices. He has attempted to shift the responsibility for this murder to society insofar as society has not restricted the activity of "Lonely Hearts" clubs throughout the country, and he over-

looks the dynamic force of the sex demands within the human being.

He consulted the defense psychiatrist but did not consult the psychiatrists for the prosecution, and he dismisses the veracity of the prosecution psychiatrists by implying that they were already primed to help in the conviction of the killers. The defense psychiatrist has published an article declaring his conclusions that Martha Beck was innocent, and Mr. Brown would lead the reader to believe that Fernandez might also be innocent. Yet it is brought out in his book that this couple were responsible for the death of at least 4 people, and that many other women were victimized. He states that Fernandez made contact with at least 205 women and that he had sex relationship with at least 100.

The author attempts to prove that the courts are entirely wrong in their definition of "insanity," and he further maintains that these 2 murderers should not have been held responsible for their crimes. He states that psychiatry is an "embryonic science," and it is obvious that his knowledge of psychiatry is limited. There is no doubt that these murderers were badly conditioned as children, and that if they had received proper treatment in their earlier days the story might have been entirely different. Certainly, society is to a great degree responsible for what happened, and something should be done to remedy the frustrations of several million "Lonely Hearts" that are found in the United States. The remedy, however, is not legislation nor restriction, but better understanding and guidance.

Any person who wants a case study of life's failures will find this book convincing. Although the author is unfair and inaccurate in many of his conclusions, he has presented a very interesting news story from which much can be learned.

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PSYCHOSURGICAL PROBLEMS. Edited by *Fred A. Mettler*. (Philadelphia: Blakiston, 1952. Price: $7.00.)

This is the report of the second Columbia-Greystone project. It details experiences with a group of patients subjected to a variety of unconventional psychosurgical procedures in the hope of exploring the field more fully and of bringing new methods to bear in treating chronic mental illness. The first report, published about 2 years previously, gave definite indications that, by the use of selective partial ablations from the frontal lobes (topectomy), a considerable number of supposedly incurable patients could be returned to society. The present report is less favorable from this standpoint and, as far as answering the question of the modus operandi of frontal lobe operations, it is even less successful. There are a number of points that are made by various of the 36 investigators, however, to make this a worth-while volume.

Twelve patients were subjected to obliteration of the superior cerebral veins. This proved unsatisfactory and at times dangerous. Cortical coagulation was employed only twice and section of the thalamus only twice. Transorbital lobotomy was carried out 9 times with 9 failures. The patients were studied in various ways, clinically, psychologically, physiologically, and sociologically both before and after their operations. A group of 6 control subjects was included in which the same therapeutic and investigative methods were employed except for operation upon the brain.

The changes dependent upon the operations were of quite limited degree, variable in their direction, and rather short in duration. Almost all the patients were back at their preoperative levels of performance within three months. "Certainly and positively there was no sound evidence that the variety of neurologic surgery conducted on the frontal lobes of these 22 patients had any important differential effect on the psychologic variables measured." There was amnesia for the operation itself and often denial that any operation had been performed. There was no significant change in attitudes. The authors speak of transient performance deficiency. The chapter on conclusions is particularly valuable as a confession of frustration. "Careful planning, high motivation, ample funds, sincere cooperation, a real problem and an energetic attack cannot produce positive data when the correct data are of a negative nature."

Upon this rather unstable foundation, the authors erect 2 alternative hypotheses to explain psychologically how it is that dread and anguish are abolished by frontal lobe operations: "1. Psychosurgery of the frontal lobes results in a narrowing of the field of attention so that there is a tendency for the patient to be stimulus-bound. 2. Surgery adds to the mental confusion of the patient. This confusion grows out of an interference with the associative bonds linking mental elements and is usually reported as a loss or decrease in the feeling of familiarity or an increase in the feeling of unreality." It is difficult to follow this reasoning unless the reader is familiar with the semantics employed by the authors. If narrowing of the field of attention and confusion are suggested as goals in therapy, it might conceivably be better to allow the schizophrenic psychosis to run its course without surgical interference. Actually, of all the symptoms of a psychosis, the feeling of unreality, as in the depersonalization syndrome, is apt to be most easily dispelled by operation. In view of the above hypotheses, there is a statement by the authors that needs clarification. "The patient with intractable pain likewise becomes less bound to or familiar with his pain following operation." More stimulus-bound in the theory, but less stimulus bound in the example. The authors admit that the hypotheses are speculative. But hypotheses are the mental groundwork upon which further experiments must be constructed in order to prove their validity. Perhaps the fault lies not in the investigations but rather in the type of material investigated. Patients with schizophrenia of 3 to 20 years' duration are most unfavorable material to work with at any level above the physiologic.

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